A CATALOGUE OF STATE MEDICAID PROGRAM CHANGES

The State Medicaid Program Information Center: 1989

SMPIC

National Governors' Association

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Most important, however, thanks are due the state Medicaid directors and their staffs for sharing information on their activities with us. We are hopeful that the program data compiled in this document will be of use to them in administering their programs and will provide some compensation for their efforts.

2. INPATIENT HOSPITAL CARE

A. Amount, Duration and Scope

AL *A 01/90 (+) Alabama increased the number of inpatient hospital days to 14 days per recipient, per calendar year. Additional days may be approved through prior authorization for EPSDT participants and for women with medically necessary days following a delivery.

AL *A 07/89 (+) Alabama now allows unlimited inpatient days for children under age one receiving medically necessary inpatient services from a Medicaid-designated disproportionate share hospital.

AL *A 01/89 (+) Alabama added bone marrow transplant as a covered service. Prior authorization is required in cases of aplastic anemia, acute leukemia, chronic leukemia, and other non-experimental situations.

AZ *A 10/89 (+) Arizona added autologous bone marrow transplants for cases in which FFP is available above the prepaid capitation amount.

AR *A 01/90 (-) Arkansas limited inpatient hospital services to 25 days per state fiscal year. In life-threatening situations for children, additional days may be approved under the EPSDT program.

AR *A 08/89 (+) Arkansas added heart, liver, and non-experimental bone marrow transplants with prior authorization.

AR *A 07/89 (-) Arkansas established an upper limit for rural acute care hospitals of $438.00 per day. This action was taken due to budgetary constraints.

CT *A 01/89 ( ) Connecticut removed its limitation restricting oral surgeries to inpatient and outpatient hospital settings. Oral surgeries may also be performed in office settings.

IL *A 07/89 (-) Illinois implemented its Exceptional Care Program to provide services for residents with exceptional care needs in long term care nursing facilities. A facility specific rate rather than a client specified rate is negotiated for a select number of beds to be utilized for the services provided. Excep-

tional care is defined as the level of medical care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physicians, nurse and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be medically necessary (includes persons with AIDS, head injured persons, and ventilator-dependent persons). For a person to be approved for exceptional care placement, the cost of the person's care must be at least 50% more than the nursing facility's per diem rate (capital, support, and nursing components). Utilization of services is subject to a 90-day review.

Providers must meet a number of criteria including:

1. acceptance of 75% of all persons approved if facility is at less than 95% occupancy;
2. demonstration of ability to provide specialized nursing and therapeutic care with shift staffing specifications; and
3. documentation of specialized training and inservicing of all staff.

KS *A 08/89 (+) Kansas added organ procurement for covered transplants with prior authorization.

MD *A 05/89 (+) Maryland removed DRG day limits for hospital stays of Medicaid recipients.

MN *A 00/89 (-) Minnesota limited organ and tissue transplants to those covered by Medicare.

NV *A 09/89 (-) Nevada no longer reimburses for observation bed charges when a patient is admitted to the hospital or after out-patient surgery.

OK *A 02/89 (-) Oklahoma limited general acute care for inpatient services to 20 days per adult per fiscal year.

OK *A 02/89 (-) Oklahoma limited inpatient hospital services for EPSDT recipients to 60 days per fiscal year. Exceptions may be granted for catastrophic illnesses.

INTRODUCTION

States have been faced with the challenge of developing policies to control the growth in their Medicaid program expenditures while striving to minimize any adverse impacts of such policies on the provision of health care to those in need. In order to make the best possible choices among alternatives, it is important that state officials have at their disposal complete information on potential policy approaches.

To address this critical information need, the National Governors' Association's Center for Policy Research, through a contract awarded by the Health Care Financing Administration, has established the State Medicaid Information Center (SMIC). The purpose of the SMIC Project is to serve as a central source of information concerning strategies adopted by individual state Medicaid programs.

This edition of A Catalogue for State Medicaid Program Changes is intended to serve as a complete and easy-to-use reference document which provides summaries of individual states' Medicaid activities. Such a guide should allow state officials to readily access the experience of other states that have pursued specific policy initiatives and expand the range of potential policy alternatives available for consideration by a state. The Catalogue was originially published in September 1981, and has been updated seven times, with this edition. This document contains abstracts of those policy changes implemented or proposed during 1989.

Both primary and secondary sources of data on state cost containment activities have been consulted in the preparation of the Catalogue, and every effort has been made to verify all information directly with each state agency. In order to provide as full and complete a data base as possible, information on state-initiated changes which have expanded the scope of their programs is presented in this document, as are some of the more significant changes which recently have been proposed but as yet have not been implemented.

Program modifications required of all states, as the result of changes in federal requirements, have not been included. Such requirements in 1989 included: preadmission screening and annual resident review (PASARR) of nursing home clients, coverage of Medicare cost-sharing payments for qualified Medicare beneficiaries (QMBs), transfer of assets standards and community spouse resource allowances for spouses of institutionalized individuals, coverage of pregnant women and infants up to 75 percent of poverty, and coverage of children up to age 6 in families with AFDC incomes.

Since the Catalogue is structured for easy revision, states will be provided on a regular basis with data on new state initiatives. This will be an especially important feature as states make use of greater policy latitude provided by recent changes in federal law. We have received a very strong, positive response to the publication of A Catalogue of State Medicaid Program Changes. It is hoped that the information presented in this Update will prove useful to state officials in their efforts to maintain access to needed health services for the nation's poor while controlling escalating Medicaid expenditures.

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HOW TO USE THIS DOCUMENT

The first section of the Catalogue, entitled "Selected State Medicaid Program Characteristics," contains several narratives and tables summarizing certain current aspects of all state Medicaid programs. The topics covered have been chosen for their timeliness, relevance, and significances for Medicaid policymakers.

The remainder of the Catalogue presents data on individual state Medicaid program changes which were implemented or proposed during 1989. Abstracts describing these changes are included under one or more of the four major sections of the Catalogue, which are the following:

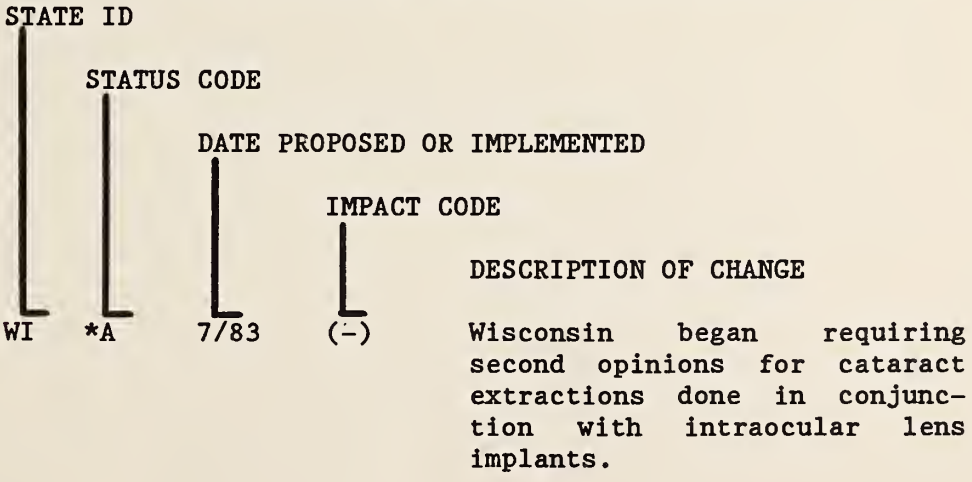
I. Services
II. Administration and Management
III. Eligibility
IV. Alternative Service Delivery/Program Management

Under Section I, Services, abstracts are listed according to the particular services a policy change affects. Under each service, abstracts are presented under one of the following subheadings, according to the nature of the policy changes.

A. Amount, Duration, and Scope
B. Utilization Controls
C. Reimbursement

A directory of the services to be found in Section I as well as the subheadings for Section II are presented in the Table of Contents, which appears at the beginning of this document.

In order to explain the general format for all Catalogue abstracts, a sample abstract of a state program change is presented below.



The **STATE ID** is two-character code which identifies the state in which the program change was implemented or proposed. A listing of these codes is presented at the end of this section.

The **STATUS CODE** indicates the latest reported status of a particular program change. The codes are:

*A Change adopted or implemented by state
*B Program change formally proposed by a state agency, pending a final decision
*D Legislature adopted

The **DATE CODE** indicates the year and, when possible, the month in which a particular change first was implemented. For proposals, only the year is shown.

The **IMPACT CODE** indicates whether the change resulted or is expected to result in an increase (+) or decrease (-) in program expenditures.

The **DESCRIPTION** is a brief statement of the program change. When possible, the abstract alos describes the policy prior to the program change.

Within each subsection, abstracts are listed alphabetically by state. Where there is more than one abstract for a given state, the listings are arranged in chronological order beginning with the most recent change.

STATE ABBREVIATIONS

ALABAMA	AL	MONTANA	MT
ALASKA	AK	NEBRASKA	NE
ARIZONA	AZ	NEVADA	NV
ARKANSAS	AR	NEW HAMPSHIRE	NH
CALIFORNIA	CA	NEW JERSEY	NJ
COLORADO	CO	NEW MEXICO	NM
CONNECTICUT	CT	NEW YORK	NY
DELAWARE	DE	NORTH CAROLINA	NC
DISTRICT OF COLUMBIA	DC	NORTH DAKOTA	ND
FLORIDA	FL	OHIO	OH
GEORGIA	GA	OKLAHOMA	OK
GUAM	GU	OREGON	OR
HAWAII	HI	PENNSYLVANIA	PA
IDAHO	ID	PUERTO RICO	PR
ILLINOIS	IL	RHODE ISLAND	RI
INDIANA	IN	SOUTH CAROLINA	SC
IOWA	IA	SOUTH DAKOTA	SD
KANSAS	KS	TENNESSEE	TN
KENTUCKY	KY	TEXAS	TX
LOUISIANA	LA	UTAH	UT
MAINE	ME	VERMONT	VT
MARYLAND	MD	VIRGINIA	VA
MASSACHUSETTS	MA	VIRGIN ISLANDS	VI
MICHIGAN	MI	WASHINGTON	WA
MINNESOTA	MN	WEST VIRGINIA	WV
MISSISSIPPI	MS	WISCONSIN	WI
MISSOURI	MO	WYOMING	WY

ABBREVIATIONS USED THROUGHOUT THE TEXT

AFDC:	Aid to families with dependent children (may also appear as ADC)
AIDS:	Acquired Immune Deficiency syndrome
ARC:	AIDS related complex
AZT:	Azidothymidine
DME:	Durable medical equipment
DRG:	Diagnosis related group
DSH:	Disproportionate share hospital
EPSDT:	Early, periodic, screening, diagnosis, and testing
FFP:	Federal financial participation
FPL:	Federal poverty level
FY:	Fiscal year
GA:	General assistance
HCBC:	Home- and community-based care
HCBS:	Home- and community-based services
HCFA:	Health Care Financing Administration
HMO:	Health care maintenance organization
ICF:	Intermediate care facility
ICF/MR:	Intermediate care facility for the mentally retarded
LPN:	Licensed practical nurse
LTC:	Long-term care
MRI:	Magnetic resonance imaging
NF:	Nursing facility
OBRA:	Omnibus Budget Reconciliation Act of «1986, or other specified year»
PAS:	Professional activities study
PCP:	Primary care physician
PRO:	Peer review organization
QMB:	Qualified Medicare beneficiary
RN:	Registered nurse
SNF:	Skilled nursing facility
SSI:	Supplemental Security Income program
TEFRA:	Tax Equity & Fiscal Responsibility Act of 1982

CATALOGUE GUIDE
A "Where-to-Find" Sampler

SUBJECT	SECTION
Administrative Days (Administratively Necessary Days)	Amount, Duration, & Scope: Inpatient Hospital
Cost-Sharing	Utilization Controls: see specific service
Home- and Community-Based Waivers	Alternative Service Delivery: Long-Term Care
Limitations on Service Coverage	Amount, Duration, & Scope: specific service
Lock-In	Utilization Controls: specific service
Medicare Crossover Claims	Administration & Management: Third Party Liability
MMIS	Administration & Management: Claims Processing
Poor Pregnant Women Coverage	Eligibility: Income Levels
Poor Pregnant Women Enhanced Services	Alternative Services Delivery: Other Approaches
Prior Authorization	Utilization Controls: Specific Service
Qualified Meidcare Beneficiaries	Eligibility: Income Levels
Reports, Client Status	Administration & Management: Reducing Eligibility Errors
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SELECTED PROGRAM CHARACTERISTICS
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I. MEDICAID ELIGIBILITY: SUMMARY STATUS OF SELECTED PROGRAM CHARACTERISTICS

The following section provides summary information of selected state Medicaid eligibility policies, including income eligibility thresholds related to the Aid to Families with Dependent Children (AFDC) program, Medically Needy Program, and OBRA-86/87 programs for low income pregnant women and children. Additionally, the optional coverage groups of Ribicoff Children and AFDC-Unemployed Parent Families are summarized.

I. Medicaid/AFDC Income Eligibility Thresholds

Generally speaking, to become eligible for AFDC and in turn, Medicaid, families must possess income below eligibility thresholds established by each state. Current law requires states to set both monthly "Need Standards" (which represent the state's definition of the minimum amount of money a family of a given size needs to subsist), and monthly "Payment Standards" (which represent the actual maximum payment a state will make to eligible families). Rules also dictate that unless a family qualifies for some amount of cash assistance, they are not eligible for Medicaid (by virtue of the AFDC program).

What is critical to understand is that, depending on how a state calculates its payments to families, either the Need Standard or the Payment Standard can drive program eligibility. That level which truly drives program eligibility is, from this point, referred to as the "Eligibility Threshold."

Presented below are examples of the three general types of payment formulas currently employed by state AFDC programs. Note that each results in a different "standard" deciding whether or not the hypothetical family qualifies.

Method 1 - State sets its Need Standard equal to its Payment Standard. A family's countable income is subtracted from the Need Standard, payment is the deficit. This method is currently used by 16 states, including AK, CA, CT, DE, KS, MN, NE, NH, NJ, NM, NY, ND, OR, RI, SD, and WY.

$400.00	Need/Payment Standard
- 301.00	Countable Income
$ 99.00	Assistant Payment

In this example, the Need Standard drives eligibility; family qualifies for AFDC and Medicaid.

Method 2 - State sets its Payment Standard below its Need Standard. To arrive at the Payment Standard, state applies a percentage reduction to the full Need Standard. Countable income is subtracted from the reduced standard, payment is the deficit. This method is currently used by 25 states, including AL, AZ, AR, DC, FL, HI, ID, IL, IN, IA, LA, MD, MS, MO, MT, NV, NC, OH, PA, TX, VT, VA, WA, WV, WI.

$400.00	Need Standard
- 25%	Reduction Rate
$300.00	
- 301.00	Countable Income
- 1.00	No Assistance Payment

In this example, the Payment Standard drives eligibility: family does not qualify for AFDC or Medicaid.

Method 3 - State sets its Payment Standard below its Need Standard. To arrive at the Payment Standard, state subtracts countable income from the full Need Standard, then applies a percentage reduction to the deficit. This method is currently used by 10 states, including CO, GA, KY, ME, MI, MS, OK, SC, TN, and UT.

$400.00	Need Standard
- 301.00	Countable Income
$ 99.00	
- 25%	Reduction Rate
$ 74.25	Assistance Payment

In this example, the Need Standard drives eligibility; family qualifies for AFDC and Medicaid. Please note that, for these states, the relatively more generous Need Standard determines who will get into the Medicaid program, yet actual AFDC cash payments to families are based on the lower, reduced standard.

The first column of Table I-1 lists the AFDC-related Medicaid "Eligibility Threshold" for families of three for each state. For comparison, these levels are then listed as a percentage of the 1989 federal poverty level. These levels are also compared against analogous eligibility thresholds for families of three under both the state's Medically Needy program (if applicable) and the state's OBRA-86/87 Pregnant Women and Children Program (if applicable).

Table I-2 lists each state's AFDC Standard of Need and Typical Maximum Payment for family sizes 1 through 4.

Under the AFDC programs, eighteen of the states increased their income eligibility thresholds during the first six months of 1989. As of July, 1989, the AFDC eligibility threshold for a family of three, in the average state, is $4,942 per year - 48.6 percent of the poverty level.

II. Medically Needy - Protected Income Level and Program Characteristics

Medically Needy persons or families are those who fit into the categorical groups covered by a state's AFDC, SSI, and Medicaid programs (i.e., they are in families with "dependent" children, are aged, blind, disabled, etc.) but who possess too much income to qualify for coverage. By incurring medical expenses, these persons can "spend-down" or reduce their income to welfare levels and become eligible in states which have opted to pick up the "medically needy." Thirty-six of 51 states administer Medically Needy programs.

The Medicaid statute allows states to set their Medically needy Income Levels (MNILs) as high as 133 and 1/3 percent of the highest AFDC cash payment for a family of similar size. Column 2 of Table I-1 displays MNILs for families of three for each state, and compares these levels to the federal poverty level. Additionally, these levels are compared against the states' AFDC and OBRA-86/87 eligibility thresholds.

Table I-3 lists each state's MNILs for family sizes 1 through 4. The annual limit for a family of three in the average state is now $6,165--61.1 percent of the federal poverty level.

III. Pregnant Women and Children - Income Eligibility Thresholds and Program Characteristics Under OBRA-86 and OBRA-87

Landmark changes contained in the Omnibus Reconciliation Act of 1986 (OBRA-86) permitted states, effective April 1, 1987, to establish expanded Medicaid programs for low income pregnant women and young children. Severing the traditional link with the AFDC program, OBRA-86 gave states authority to establish special income thresholds above existing AFDC levels but no higher than the federal poverty level. Beginning in April 1987, these levels could be used to determine eligibility for pregnant women and infants under age one. In October 1987, the law permitted states to extend the enhanced coverage to children under age two, and raise this age limit by one year each subsequent October to the upper age limit of five. Thus, by October 1989, the upper age limit for children was raised to age four.

Additional provisions within OBRA-86 permitted Medicaid programs to simplify eligibility processes for these high priority populations. One provision allowed states to eliminate all resource restrictions for pregnant women and their children. If states retained an assets test, the law states that such limits for pregnant women could be no more restrictive than those used under the Supplemental Security Income (SSI) program. For children, resource limits could be no more restrictive than those used under the AFDC program. OBRA-86 also gave states the option to forego the usual AFDC

eligibility predetermination process in order to grant pregnant women, once determined eligible, continuous eligibility throughout their pregnancy until 60 days post-partum. Finally, the Act gave states the option of granting pregnant women short-term, presumptive eligibility status while their formal eligibility is being determined.

Building incrementally upon the previous year's law, the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) gave states even more flexibility to expand eligibility for low-income pregnant women and children. Effective July 1, 1988, states were allowed to expand income eligibility thresholds for pregnant women and infants (under age one) as high as 185 percent of the federal poverty level. As is the case with OBRA-86, states can choose to raise thresholds to any point between existing levels and the upper limit of 185 percent. Under OBRA-87, states retain the flexibility to waive assets restrictions for these groups and provide continuous eligibility throughout the pregnancy and 60 days postpartum.

OBRA-87 provided states with the option to impose an income-related premium on pregnant women and infants with incomes between 150 and 185 percent of the poverty level. The monthly premium may not exceed 10 percent of the amount by which the family's countable income exceeds 150 percent of the poverty level.

Coverage of children under OBRA-87 was permitted to be accelerated. Rather than follow the annual phase-in schedule of OBRA-86, states were allowed on July 1, 1989, to immediately cover all children living below 100 percent of poverty under the age of five. Phased-in coverage of children under the ages of 6, 7, and 8 was also permitted on a year-by-year basis.

It should also be noted that OBRA-87 contained a mandate that states cover all children, regardless of family structure, born after September 30, 1983 up to the age of seven who live in families with income and resources below a state's AFDC program levels. This provision built upon the mandate contained in the Deficit Reduction Act of 1984, which required phased-in coverage of all such children up to the age of five.

Column 3 of Table I-1 illustrates which states have adopted expanded programs for pregnant women and children under OBRA-86 and OBRA-87 authority as of July 1989. The special income eligibility threshold set by each state, for family size three, is displayed and also presented as a percent of the federal poverty level. Additionally, these levels are compared against the state's AFDC and Medically Needy eligibility thresholds. In July 1989, the eligibility threshold in the average state for pregnant women and children under OBRA-86/87 was $14,617 or 144.1 percent of the federal poverty level. The dollar amount represents a $2,643 average increase during the first 6 months of the year.

Table I-5 details the specifications of each state's OBRA-86 program. Information listed includes percent of poverty selected, upper age limit of covered children, whether or not the state dropped its assets test, whether or not the state elected the continuous eligibility clause, and whether or not the state adopted the presumptive eligibility option. Finally, initial effective dates of the OBRA-86/87 programs are displayed.

As of July 1989, 45 states had adopted OBRA-86/87 expansions. Twenty states have raised thresholds above the federal poverty level to as high as 185 percent of poverty, 24 states have established limits at 100 percent of poverty, and five maintain levels at 75 percent of poverty in compliance with minimum coverages mandated by the Medicare Catastrophic Act of 1988.

Nineteen states have taken advantage of OBRA-87 flexibility to accelerate coverage of children to those between the ages of 5 and 8, while 19 other states currently cover children between the ages of 2 and 5. Approximately one-third of the states (13) which have adopted OBRA-86/87 coverage continue to limit their coverage to children under age one.

In an encouraging effort to simplify and streamline eligibility systems, fully 42 of the 45 states which adopted OBRA-86/87 expansions have done away with resource restrictions, while 41 have guaranteed pregnant women continuous eligibility throughout their pregnancy, regardless of fluctuations in income. Finally, 23 states have adopted the presumptive eligibility option in order to extend temporary eligibility to women so that they can receive Medicaid-reimbursed prenatal care while their formal application is being reviewed.

IV. Ribicoff Children

To meet AFDC categorical eligibility rules, children must be "dependent" (i.e., deprived of the support of a parent) and thus tend to come from single-parent households. The Ribicoff Child option under Medicaid allows states to reach all other children who are poor enough to qualify for AFDC, but who do not meet the definition of "dependency." These children generally come from intact two-parent households, or state supported foster care programs and adoption programs, or are institutionalized. States can cover all of these children or select subgroups, under age 21, 20, 19, or 18.

Table I-6 illustrates states' current coverage of this optional group and again, notes effective dates. To summarize, all states have some type of Ribicoff coverage. Thirty states cover all children under an upper age limit of 18, 19, 20, or 21 (twenty of the thirty set the age limit at the maximum of 21 years). Nineteen states cover only selected subgroups of these children. All states are required, by virtue of the Deficit Reduction Act of 1984 (DEFRA) to cover all poor children born on or after 10/1/83 up to age five regardless of family structure considerations.

V. AFDC - Unemployed Parent Families

States presently also have the option to provide AFDC cash assistance and Medicaid, or to provide just Medicaid coverage, of two-parent families with an unemployed principal wage earner. Like Ribicoff Children, these families are poor enough to qualify for AFDC and Medicaid, but do not meet the categorical restrictions of "dependency" because two parents are present in the household. The reasoning behind this option is that, while two parents are present in the household, children in these families are still "dependent" because they lack the support of the principal wage earner. Pregnant women in these families were specifically targeted by DEFRA and are now covered in all states.

Table I-6 illustrates which states have opted to cover all persons in AFDC-UP families, and notes the effective dates of such coverage. To summarize, 29 states now cover AFDC-UP families for cash assistance and Medicaid, while six provide just Medicaid coverage. Seventeen states have not, as yet, opted to provide benefits to these types of families.

VI. Qualified Medicare Beneficiaries

In previous years, Medicaid programs could choose to pay Medicare cost-sharing expenses for their recipients who were also Medicare eligible. Beginning in January 1989, such payments are required for certain poor Medicare persons whether or not they are Medicaid eligible. The Medicare Catastrophic Coverage Act of 1988 requires coverage of Medicare premiums,

deductibles, and coinsurance for Medicare Part A eligible persons with incomes up to 85 percent of poverty and resources up to two times the Supplemental Security Income program resource standard. Thus, in 1989, an elderly individual could qualify for this cost-sharing coverage if he or she had income up to $5,083 and resources up to $4,000.

On January 1, 1990, states are required to cover these qualified Medicare beneficiaries (QMBs) up to 90 percent of poverty. The resource limit remains the same. The mandated phase-in continues until QMBs are covered up to 100 percent of poverty in January 1992. A more gradual phase-in was granted to states that as of Janary 1987 used more restrictive income standards for persons over age 65 than those used by the SSI program. Three states are following the 5-year phase-in plan and will reach 100 percent of poverty by January 1993.

While QMB coverage was mandated at 85 percent of poverty states were allowed to choose a higher percentage, up to 100 percent. Twelve states opted for the automatic phase-in up to 100 percent. The QMB program renewed interest in the OBRA '87 option to extend Medicaid coverage to the aged up to 100 percent of poverty. Four states selected this option in 1989. All but one state with this option, matches the percentage of poverty for this group to the percentage used for QMBs, thus somewhat simplifying eligibility and coverage issues relating to this group.

TABLE I-1

ANNUALIZED MEDICAID ELIGIBILITY THRESHOLDS a

AFDC, MEDICALLY NEEDY, OBRA 86/87 PREGNANT WOMEN – JULY 1989

	AFDC FAMILY OF 3	PERCENT OF POVERTY $10,060	MEDICALLY NEEDY FAMILY OF 3	PERCENT OF POVERTY $10,060	OBRA-86/87 PREGNANT WOMEN FAMILY OF 3	PERCENT OF POVERTY $10,060 *b*	
Alabama	$1,416	14.1%	$------		$10,060	100.0%	
Alaska	9,708	77.2%			12,580	100.0%	
Arizona	3,516	35.0%			10,060	100.0%	
Arkansas	2,448	24.3%	3,300	32.8%	10,060	100.0%	
California	8,328	82.8%	10,704	106.4%	18,611	185.0%	
Colorado	5,052	50.2%			7,545	75.0%	*
Connecticut	6,660	66.2%	8,857	88.0%	18,611	185.0%	
Delaware	3,996	39.7%			10,060	100.0%	
D.C.	4,716	46.9%	6,288	62.5%	10,060	100.0%	
Florida	3,444	34.2%	4,596	45.7%	15,090	150.0%	
Georgia	4,968	49.4%	4,404	43.8%	10,060	100.0%	
Hawaii	7,224	62.4%	7,224	62.4%	21,405	185.0%	
Idaho	3,780	37.6%			7,545	75.0%	*
Illinois	4,104	40.8%	5,496	54.6%	10,060	100.0%	
Indiana	3,456	34.4%			10,060	100.0%	
Iowa	4,920	48.9%	6,600	65.6%	18,611	185.0%	
Kansas	4,920	48.9%	5,760	57.3%	15,090	150.0%	
Kentucky	6,312	62.7%	3,696	36.7%	12,575	125.0%	
Louisiana	2,280	22.7%	3,096	30.8%	10,060	100.0%	
Maine	7,584	75.4%	7,092	70.5%	18,611	185.0%	
Maryland	4,752	47.2%	5,508	54.8%	18,611	185.0%	
Massachusetts	6,948	69.1%	9,300	92.4%	18,611	185.0%	
Michigan	6,900	68.6%	6,660	66.2%	18,611	185.0%	
Minnesota	6,384	63.5%	8,508	84.6%	18,611	185.0%	
Mississippi	4,416	43.9%			18,611	185.0%	
Missouri	3,420	34.0%			10,060	100.0%	
Montana	4,308	42.8%	4,896	48.7%	10,060	100.0%	
Nebraska	4,368	43.4%	5,904	58.7%	10,060	100.0%	
Nevada	3,960	39.4%			7,545	75.0%	*
New Hampshire	6,072	60.4%	6,900	68.6%	7,545	75.0%	*
New Jersey	5,088	50.6%	6,792	67.5%	10,060	100.0%	
New Mexico	3,168	31.5%			10,060	100.0%	
New York	6,468	64.3%	8,508	84.6%	18,611	185.0%	
North Carolina	3,192	31.7%	4,296	42.7%	10,060	100.0%	
North Dakota	4,632	46.0%	5,220	51.9%	7,545	75.0%	*
Ohio	3,852	38.3%			10,060	100.0%	
Oklahoma	5,652	56.2%	5,196	51.7%	10,060	100.0%	
Oregon	5,184	51.5%	6,900	68.6%	8,591	85.4%	
Pennsylvania	4,608	45.8%	5,400	53.7%	10,060	100.0%	
Rhode Island	6,516	64.8%	8,700	86.5%	18,611	185.0%	
South Carolina	5,028	50.0%			18,611	185.0%	
South Dakota	4,524	45.0%			10,060	100.0%	
Tennessee	4,644	46.2%	3,000	29.8%	10,060	100.0%	
Texas	2,208	21.9%	3,204	31.8%	13,078	130.0%	
Utah	6,192	61.6%	6,192	61.6%	10,060	100.0%	
Vermont	7,812	77.7%	10,500	104.4%	18,611	185.0%	
Virginia	3,492	34.7%	4,296	42.7%	10,060	100.0%	
Washington	5,904	58.7%	7,188	71.5%	18,611	185.0%	
West Virginia	2,988	29.7%	3,480	34.6%	15,090	150.0%	
Wisconsin	6,204	61.7%	8,268	82.2%			
Wyoming	4,320	42.9%			10,060	100.0%	
AVG. STATE	$4,942	48.6%	$6,165	61.0%	$14,617	144.1%	

* COMPLYING WITH FEDERAL MANDATE

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE I-1

ANNUALIZED MEDICAID ELIGIBILITY THRESHOLDS a
AFDC, MEDICALLY NEEDY,
OBRA 86/87 PREGNANT WOMEN – JULY 1989

NOTES:

a. AFDC and Medically Needy thresholds current through July 1989. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the Payment Standard. In COLORADO, GEORGIA, KENTUCKY, MAINE, MICHIGAN, MISSISSIPPI, OKLAHOMA, SOUTH CAROLINA, TENNESSEE and UTAH, the threshold is the state's Need Standard. Please note, in these ten states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' Payment Standards are actually significantly lower than the eligibility threshold.

b. Poverty levels for Hawaii and Alaska differ from other states: Alaska - family of three = $12,580; Hawaii - family of three = $11,570.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, JULY 1989

TABLE I-2

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
MONTHLY NEED AND PAYMENT AMOUNTS - SEPTEMBER 1989

	FAMILY OF ONE		FAMILY OF TWO		FAMILY OF THREE		FAMILY OF FOUR	
	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT	NEED STANDARD	MAXIMUM PAYMENT
Alabama	$390	$59	$479	$88	$571	$118	$670	$147
Alaska	453	453	719	719	809	809	899	899
Arizona	367	173	494	233	621	293	748	353
Arkansas	280	81	560	162	705	204	850	247
California	341	341	560	560	694	694	824	824
Colorado	253	214	331	280	421	356	510	432
Connecticut	340	340	452	452	555	555	652	652
Delaware	184	184	247	247	333	333	402	402
DC	450	248	560	309	712	393	870	480
Florida	498	163	668	220	838	287	1008	338
Georgia	229	151	347	229	414	273	488	322
Hawaii	572	357	768	480	964	602	1160	725
Idaho	365	208	446	254	554	315	627	357
Illinois	427	198	539	250	740	342	835	386
Indiana	155	139	255	229	320	288	385	346
Iowa	213	176	421	347	497	410	578	476
Kansas	243	243	330	330	410	410	480	480
Kentucky	394	162	460	196	526	228	592	285
Louisiana	245	72	472	138	658	190	809	234
Maine	299	207	470	326	632	438	794	551
Maryland	243	175	428	309	548	396	660	477
Massachusetts	392	392	486	486	579	579	668	668
Michigan	348	291	466	388	575	479	702	585
Minnesota	250	250	437	437	532	532	621	621
Mississippi	218	60	293	96	368	120	443	144
Missouri	145	134	250	232	312	289	365	338
Montana	256	212	346	286	434	359	523	433
Nebraska	222	222	293	293	364	364	435	435
Nevada	350	210	450	270	550	330	650	390
New Hampshire	380	380	442	442	506	506	563	563
New Jersey	162	162	322	322	424	424	488	488
New Mexico	156	156	210	210	264	264	317	317
New York	334	334	439	439	539	539	639	639
North Carolina	354	177	462	231	532	266	582	291
North Dakota	209	209	313	313	386	386	472	472
Ohio	440	191	606	263	739	321	914	397
Oklahoma	291	201	364	252	471	325	583	403
Oregon	289	289	369	369	432	432	526	526
Pennsylvania	298	195	461	315	587	402	724	490
Rhode Island	321	321	440	440	543	543	620	620
South Carolina	249	123	335	165	419	206	504	248
South Dakota	265	265	333	333	377	377	421	421
Tennesee	198	94	297	141	387	184	472	224
Texas	235	75	493	158	574	184	691	221
Utah	299	224	414	310	516	387	603	452
Vermont	670	448	817	547	973	651	1090	730
Virginia	174	157	257	231	322	291	386	347
Washington	579	314	733	397	907	492	1068	578
West Virginia	289	145	401	201	497	249	623	312
Wisconsin	311	248	550	440	647	517	772	617
Wyoming	195	195	320	320	360	360	390	390

SEE NOTES ON NEXT PAGE

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE I-2

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
MONTHLY NEED AND PAYMENT AMOUNTS - JANUARY 1989

NOTES:

IN A NUMBER OF STATES, NEED AND PAYMENT AMOUNTS VARY DEPENDING ON FACTORS SUCH AS REGION, SEASON (SUMMER OR WINTER), AND WHAT COMPONENTS ARE INCLUDED IN THE STANDARD (E.G., RENTAL ALLOWANCE. IN ALL SUCH CASES, THE REGION WITH THE HIGHEST CONCENTRATION OF RECIPIENTS AND/OR THE HIGHEST SEASONAL RATE IS DISPLAYED. DETAILED NOTES BY STATE (WHERE APPLICABLE) APPEAR BELOW.

CT - REGION B
KS - METROPOLITAN AREAS
LA - URBAN AREAS
MA - RENTAL ALLOWANCE INCLUDED
MI - ANNUALIZED SUMMER/WINTER AVERAGE
NY - NEW YORK CITY REGION
PA - PHILADELPHIA REGION
VT - CHITTENDEN COUNTY
VA - GROUP 2
WI - AREA 1

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE I-3

MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS
FAMILY SIZE ONE THROUGH FOUR - SEPTEMBER 1989

	FAMILY OF ONE	FAMILY OF TWO	FAMILY OF THREE	FAMILY OF FOUR
Alabama	N/A	N/A	N/A	N/A
Alaska	N/A	N/A	N/A	N/A
Arizona	N/A	N/A	N/A	N/A
Arkansas	$108	$217	$275	$333
California	600	750	934	1110
Colorado	N/A	N/A	N/A	N/A
Connecticut	452	601	738	867
Delaware	N/A	N/A	N/A	N/A
DC	391	412	524	640
Florida	300	300	383	458
Georgia	208	308	367	433
Hawaii	357	480	602	725
Idaho	N/A	N/A	N/A	N/A
Illinois	267	333	458	517
Indiana	N/A	N/A	N/A	N/A
Iowa	466	466	550	633
Kansas	368	475	480	506
Kentucky	217	267	308	383
Louisiana	100	192	258	317
Maine	400	441	591	741
Maryland	375	417	459	500
Massachusetts	483	650	775	891
Michigan	391	525	555	585
Minnesota	466	582	709	828
Mississippi	N/A	N/A	N/A	N/A
Missouri	N/A	N/A	N/A	N/A
Montana	368	383	408	433
Nebraska	392	392	492	584
Nevada	N/A	N/A	N/A	N/A
New Hampshire	382	554	575	597
New Jersey	350	433	566	658
New Mexico	N/A	N/A	N/A	N/A
New York	459	659	709	850
North Carolina	242	308	358	392
North Dakota	345	400	435	530
Ohio	N/A	N/A	N/A	N/A
Oklahoma	275	341	433	541
Oregon	385	491	575	701
Pennsylvania	408	425	450	542
Rhode Island	550	592	725	833
South Carolina	N/A	N/A	N/A	N/A
South Dakota	N/A	N/A	N/A	N/A
Tennessee	175	192	250	300
Texas	100	211	267	301
Utah	337	413	516	602
Vermont	733	733	875	975
Virginia	250	308	358	400
Washington	396	532	599	667
West Virginia	200	275	290	312
Wisconsin	471	592	689	823
Wyoming	N/A	N/A	N/A	N/A

N/A = Not applicable - state has no medically needy program.
SEE NOTES ON NEXT PAGE.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE I-3

MEDICALLY NEEDY MONTHLY PROTECTED INCOME LEVELS
FAMILY SIZE ONE THROUGH FOUR - SEPTEMBER 1989

NOTES:

In a number of states, need and payment amounts vary depending on factors such as regions, season (summer or winter) and what components are included in the standard (e.g., rental allowance). In all such cases, the region with the highest concentration of recipients and/or the highest seasonal rate is displayed. Detailed notes by state (where applicable) appear below.

CT - REGION B
KS - METROPOLITAN AREAS
LA - URBAN AREAS
MA - RENTAL ALLOWANCE INCLUDED
MI - ANNUALIZED SUMMER/WINTER AVERAGE
NY - NEW YORK CITY REGION
PA - PHILADELPHIA REGION
VT - CHITTENDEN COUNTY
VA - GROUP 2
WI - AREA 1

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE I-4

COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN, AS OF SEPTEMBER 1989

	PREGNANT WOMEN AND INFANTS PERCENT POVERTY	OLDER CHILDREN COVERED UNDER POVERTY TO AGE 6*	DROPPED ASSETS TEST	CONTINUOUS ELIGIBILITY	PRESUMPTIVE ELIGIBILITY	ORIGINAL EFFECTIVE DATE
Alabama	100		X	X	X	7/88
Alaska	100	3	X	X		1/89
Arizona	100	6	X	X		1/88
Arkansas	100	6	X	X	X	4/87
California	185					7/89
Colorado	75***				X**	7/89
Connecticut	185		X	X		4/88
Delaware	100	3	X	X		1/88
DC	100	3	X	X		4/87
Florida	150	6	X	X	X	10/87
Georgia	100	3	X	X		1/89
Hawaii	185**	5	X	X	X	1/89
Idaho	75***		X	X	X	1/89
Illinois	100			X	X	7/88
Indiana	100	3	X	X	X	7/88
Iowa	185	6		X	X	1/89
Kansas	150	5	X			7/88
Kentucky	125	2		X		10/87
Louisiana	100	6	X	X	X	1/89
Maine	185	6	X		X	10/88
Maryland	185	2	X	X	X	7/87
Massachusetts	185	5	X	X	X	7/87
Michigan	185	3	X	X		1/88
Minnesota	185	6	X	X		7/88
Mississippi	185	5	X	X		10/87
Missouri	100	3		X		1/88
Montana	100		X			7/89
Nebraska	100	3	X	X	X	7/88
Nevada	75***	6	X			7/89
New Hampshire	75***		X			7/89
New Jersey	100	2	X	X	X	7/87
New Mexico	100	3	X	X	X	1/88
New York	185		X	X	X	1/90**
North Carolina	100	6	X	X	X	10/87
North Dakota	75***					7/89
Ohio	100		X	X		1/89
Oklahoma	100	2	X	X		1/88
Oregon	85	3	X	X		11/87
Pennsylvania	100	3	X		X	4/88
Rhode Island	185	6	X	X		4/87
South Carolina	185	6	X	X		10/87
South Dakota	100	2	X	X		7/88
Tennessee	100	5	X	X	X	7/87
Texas	130	4		X	X	9/88
Utah	100		X	X	X	1/89
Vermont	185	6	X	X		10/87
Virginia	100	2	X	X		7/88
Washington	185	6	X	X		7/87
West Virginia	150	6	X	X		7/87
Wisconsin	****				X	4/88
Wyoming	100		X	X		10/88
TOTAL	45	37	42	41	23	

* THIS COLUMN DOES NOT INCLUDE CHILDREN'S COVERAGE GROUPS SUPPORTED BY STATE ONLY FUNDS.

** FUTURE IMPLEMENTATION DATE

*** COMPLIANCE WITH MINIMUM MANDATED COVERAGE

**** STATE FUNDED PROGRAM COVERS PREGNANT WOMEN AND INFANTS BELOW 120% OF POVERTY

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE I-5

STATE COVERAGE OF RIBICOFF CHILDREN, AFDC-UP FAMILIES, AND QUALIFIED MEDICARE BENEFICIARIES, AS OF JULY 1989

	RIBICOFF CHILDREN		AFDC-UP FAMILIES			QUALIFIED MEDICARE BENEFICIARIES (QMB'S)
	ALL UNDER AGE	REASONABLE UNDER AGE	AFDC CASH AND MEDICAID	MEDICAID-ONLY	DOES NOT COVER	% OF 1989 POVERTY
Alabama		18			X	85
Alaska	21				X	100
Arizona	18				X	85
Arkansas	18				X	85
California	21		X			85
Colorado		21			X	85
Connecticut	21		X			85
Delaware		21	X			85
Dist. of Columbia	21		X			100
Florida	18			X		100
Georgia	18			X		85
Hawaii		19/21	X			100
Idaho		18/21			X	85
Illinois	18		X			80
Indiana		21			X	80
Iowa	21		X			85
Kansas	18		X			85
Kentucky		19		X		85
Louisiana		18		X		85
Maine	21		X			85
Maryland	21		X			85
Massachusetts	21		X (19)	X (21)		100
Michigan	21		X			85
Minnesota	21		X			85
Mississippi	18				X	85
Missouri		21	X			85
Montana		21	X			85
Nebraska	21		X			85
Nevada		19			X	100
New Hampshire		19/18			X	85
New Jersey	21		X			100
New Mexico		18/21			X	85
New York	21		X			100
North Carolina	21		X			80
North Dakota	21				X	85
Ohio	21		X			80
Oklahoma	21			X		90
Oregon		18/21	X			85
Pennsylvania	21		X			100
Rhode Island		18/21	X			85
South Carolina	18		X			100
South Dakota		21			X	85
Tennessee	21				X	85
Texas	19				X	85
Utah	18				X	100
Vermont	21		X			86
Virginia		21			X	85
Washington		21	X			85
West Virginia		18	X			85
Wisconsin	18		X			100
Wyoming		19			X	85
TOTAL	31	19	29	6	18	

SOURCE: NATIONAL GOVERNORS' ASSOCIATION

II. STATE MEDICAID INPATIENT HOSPITAL REIMBURSEMENT AND COVERAGE

Introduction

Historically, as an individual service, hospital expenditures have represented the largest proportion of the Medicaid program. Hospital services have continually consumed slightly over one-quarter of Medicaid expenditures.

In fiscal year 1980 Medicaid inpatient hospital services cost state and federal government a total of $6.3 billion. By 1988 total state and federal inpatient hospital services were $12 billion for 3.7 million recipients. This amount represents approximately 25 percent of the total amount spent on Medicaid services.

Background

Medicaid reimbursement of inpatient services is guided by provisions of the Omnibus Budget Reconciliation Act of 1981 (OBRA '81). Said to have made the most substantial changes in the Medicaid program since its inception in 1965, OBRA '81 enabled states to move away from reasonable cost-based payment methods and set ceilings on rates of payment that are independent of what a particular hospital spends or of increases in the costs of goods and services used by the hospital. State payment for inpatient hospital services must be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities, meeting state and federal laws and regulations as well as quality and safety standards. The new law required state rates to be sufficient to assure that Medicaid patients have reasonable access to quality services.

In addition, OBRA '81 established a provision requiring states to take into account hospitals serving a disproportionate number of low income patients. Since OBRA '81, several pieces of legislation have been targeted at the calculation of hospital rates, specifically for disproportionate share hospitals. OBRA '86 prohibited limits on the amount of payment adjustments under the state Medicaid plan with respect to hospitals serving a disproportionate number of low income patients with special needs. Later, OBRA '87 was added requiring states to define disproportionate share hospitals and increase payment rates for inpatient services provided by these hospitals.

While coverage of inpatient hospital services is required by federal statute, states have authority over various aspects of the services, within federal statutory parameters. For example, states specify the amount, duration, and scope of hospital services sufficient to reasonably achieve their purpose. States may also impose limits focused on amount, duration, and scope. Limiting services also serves to constrain costs by preventing the program from paying for unnecessary care. (See "Program Changes Affecting The Medicaid Hospital Services," NGA, December 1987.)

In addition to service restrictions, states have implemented a variety of utilization controls. The most commonly used methods focus on monitoring to assure that patient admissions are medically necessary, and screening to ensure that the patient could not be appropriately cared for in an outpatient setting.

Finally, there are other services that can be provided in the hospital setting. These include: skilled nursing services, rehabilitation services, psychiatric services, and drug and alcohol treatment services. Each of these services carries its own definition and payment methods.

Data Summary

The following series of tables displays information on Medicaid inpatient payment method, coverage of bed type, as well as annual and summary characteristics of inpatient hospital expenditures and recipients.

Although states' Medicaid acute care inpatient reimbursement systems vary widely, for descriptive purposes, they have been classified into four broad categories. The first category, used by twenty states, sets prospective rates unadjusted by either diagnosis related groups (DRGs) or the actual costs or charges related to particular care. The second category is similar to the first except that the prospective rates are weighted by DRG for each individual case. Seventeen states set prospective rates adjusted for the DRG associated with the case. The third category of payment, used by ten states, calculates rates based on the lesser of: a prospective rate or a percentage of either costs or charges. Finally, four states reimburse hospitals based on a percentage of their costs or charges, typically using Medicare principles.

Prospective rate setting is the method preferred by the states. Typically this is done by using costs to establish a rate for a base year and then trending forward for future years using the inflation index or another index. Forty-seven states use some form of prospective rate-setting. Within this category, however, states base their payments on different criteria. Seventeen use DRGs, sixteen states reimburse on a per diem basis, and fourteen reimburse based on discharge.

Maryland is the only state that uses a system in which Medicaid is part of a pure all-payer payment system. In an all-payer system Medicaid pays hospitals through the same methodology, and in some cases at the same rate as other public and private payers. New York's and New Jersey's payment systems include other payers with Medicaid. In New Jersey and New York, unlike Maryland, Medicare does not participate in the all payer system.

Two states, California and Illinois, selectively contract for inpatient hospital services and payment. Under this method, made possible through use of federal waiver authority, hospitals bid for price or volume of services.

Rates can also be established for individual hospitals or for a group of hospitals. Some states group hospitals by the number of beds or by rural or urban distinction to form a peer group. In this case, prospective payment rates are based on the peer group's typical costs for treating Medicaid patients.

Thirty of the forty-seven states which have prospective rates compute averages for individual hospitals rather than compute an average for a peer group. Three states calculate payment based on a blend of hospital-specific rates and peer group rates. Other methods of calculating prospective rates include using historical or expected costs to establish a rate (two states) or computing a prospective payment for all general acute hospitals within the state (five states).

States may choose to cover various types of services in a hospital including; swing-beds, skilled nursing beds, rehabilitation beds, psychiatric beds, and alcohol and drug treatment beds. While the information we received on the number of facilities and the number of beds is somewhat limited, it appears from the variation in the number of beds allocated for such services that some states make more use of these options than others, based on their needs.

Swing-beds allow hospitals to be reimbursed for providing certain types of post-acute care, without designating beds exclusively to either acute or post-acute care. Given the popularity of swing-beds under Medicare, it is surprising that only thirty-two states reported coverage of swing-beds.

As the average length of stay continues to decline and the number of admissions also declines, hospitals are increasing the use of non-acute inpatient services such as skilled nursing facility (SNF) units, rehabilitation services, psychiatric services, and alcohol and drug treatment services. Thirty-five states reported coverage of SNF units within their general hospitals. The majority of states indicated that they cover rehabilitation (forty-five) and psychiatric units (forty-three) within general hospitals. However, the number of states indicating coverage of alcohol and drug units is lower (thirty-six). One likely reason for more widespread coverage of rehabilitation and psychiatric services compared with swing-beds and SNF units is that most states only cover rehabilitation and psychiatric services within institutions.

Finally, enclosed is a series of tables (II-3 - II-7) presenting data on inpatient hospital use and expenditures for 1985 through 1988. The data for this section were collected from the HCFA - 2082 report. Because some of these numbers may be estimates, this information should be used purely for descriptive purposes and should not be used to make comparisons.

However, generally Table II-3 shows that inpatient expenditures grew at an annual rate of about 11 percent between 1985-1989. On the other hand, the average cost for each recipient grew, on average, at a slower rate of about 6 percent. With overall expenditures growing almost twice as fast as the expenditures per recipient, this data suggests that Medicaid is covering larger numbers of hospital inpatients and spending increasingly more per inpatient visit.

For 1988, total Medicaid inpatient expenditures (table II-4) continue to represent approximately one quarter of the $48 billion that make up total Medicaid expenditures. These dollars provided coverage for approximately 3.7 million inpatient hospital recipients at an average cost of $3,048 per recipient. One-quarter of total Medicaid expenditures is consistent with the proportions spent in recent years. However, it does reflect a slight decrease in inpatient expenditures of earlier years, when inpatient expenditures

consistently represented 30 percent of Medicaid expenditures. It is likely that this slight decrease in inpatient expenditures, as a percentage of total Medicaid expenditures, can be attributed to the gradual shift of many inpatient procedures to outpatient settings.

Conclusion

Although we hesitate to draw conclusions, for the reasons mentioned above, some trends in this data are apparent. Almost all states are using prospective payment systems to establish hospital rates. Within prospective systems, states vary their payment policies using per diem, per discharge and DRGs about equally. States are also experiencing growth in both Medicaid inpatient hospital expenditures and the number of recipients. While there may be some general statements about Medicaid inpatient hospital services, based on this data, the diversity across states is significant enough to temper any broad conclusions.

If you have any questions you may contact John Luehrs at (202) 624 - 7812 or Amanda Hock at (202) 624 - 5349.

TABLE II-1

MEDICAID HOSPITAL INPATIENT FACILITIES AND REIMBURSEMENT METHODS

State	Reimbursement Method			Medicaid Inpatient Facilities	
	Prospective Rates	Diagnoses Weighted	% of Costs or Charges	# of Beds	# of Facilities
Alabama	A (1)			19,922	119
Alaska	B			1,278	17
Arizona					
Arkansas	A			N/A	88
California	B (1,2)		#	107,200	559
Colorado	B	X		12,830	98
Connecticut	B			11,049	37
Delaware			X	N/A	N/A
District of Columbia	B			N/A	N/A
Florida	A (1)		#	55,715	243
Georgia	C			25,927	172
Hawaii	A			2,855	23
Idaho	A		#	2,876	44
Illinois	A (2)			60,000	28
Indiana	B		#	25,919	123
Iowa	B (3)	X		15,326	127
Kansas	B	X		N/A	N/A
Kentucky	A		#	17,586	108
Louisiana	B		#	N/A	N/A
Maine	B			5,372	44
Maryland	D			12,522	500
Massachusetts	B (4)			22,212	110
Michigan	B	X	#	43,230	213
Minnesota	C	X		19,546	163
Mississippi	A		#	12,748	109
Missouri	A			32,252	165
Montana	B	X		N/A	57
Nebraska	A			12,166	108
Nevada	B (5)			4,003	32
New Hampshire	B	X		N/A	N/A
New Jersey	B	X		30,934	89
New Mexico	B (1)		#	4,578	40
New York	B (3)			N/A	264
North Carolina	A			30,970	146
North Dakota	B	X		N/A	N/A
Ohio	B	X		44,721	194
Oklahoma	A			N/A	N/A
Oregon	B	X		8,960	71
Pennsylvania	B (3)	X		54,690	229
Rhode Island	A (8)			N/A	N/A
South Carolina	B (6)	X		12,107	112
South Dakota	B (1)	X		N/A	55
Tennessee	A			N/A	N/A
Texas	C	X		N/A	440
Utah	B (7)	X		4,613	42
Vermont	A			1,603	16
Virginia	A		#	25,026	110
Washington	B	X		11,759	107
West Virginia			X	10,689	69
Wisconsin	B			N/A	N/A
Wyoming			X	1,781	30
TOTAL	**47**	**17**	**13**		

SOURCE: NGA, State Medicaid Information Center

TABLE II-1

KEY:
- A = PER DIEM
- B = PER DISCHARGE
- C = PER ADMISSION
- D = PER SERVICE

NOTES:
- # = IF A STATE IS MARKED IN BOTH COLUMN 1 AND 3, PAYMENT EQUALS THE LESSER OF THE TWO AMOUNTS.
1. HOSPITAL SPECIFIC UP TO PEER GROUP CEILING.
2. NEGOTIATED CONTRACTS (ONE OF SEVERAL ALTERNATIVE SYSTEMS IN CALIFORNIA.
3. BLEND OF HOSPITAL SPECIFIC AND PEER GROUP RATES.
4. HOSPITAL'S BUDGET ADJUSTED FOR ANY EXCESS CHARGES IN PREVIOUS YEAR.
5. PER DIEM RATE AFTER FIFTEENTH DAY.
6. HOSPITAL SPECIFIC PER DIEM RATES FOR INFREQUENT DRSs.
7. RURAL HOSPITALS PAID 95 PERCENT OF CHARGES.
8. BASED ON NEGOTIATED HOSPITAL BUDGETS.

SOURCE: NGA, State Medicaid Information Center

TABLE II-2

MEDICAID COVERAGE FOR VARIOUS BED TYPES WITHIN GENERAL ACUTE CARE HOSPITALS

	SWING-BEDS			SKILLED NURSING			REHABILITATION			PSYCHIATRIC			ALCOHOL/DRUGS		
	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS
AL	X	2	20	X			X (a)			X (a)	32	1202	X (a)	15	235
AK	X	9	24	X	7	125	X			X	3	77	X	2	34
AZ	X	N/A		X	N/A		X	N/A							
AR		N/A	N/A		N/A		X	N/A		X			X		
CA	X	N/A	N/A	X	N/A		X			X	N/A	N/A		N/A	N/A
CO				X			X			X	N/A	N/A	X	N/A	N/A
CT							X (a)			X (a)			X (a)		
DE							X			X			X		
DC				X			X			X					
FL	X	30		X (c)	45		X (a)			X (a)	N/A	N/A	X	N/A	N/A
GA	(e)			X			X			X	N/A	N/A	X	N/A	N/A
HI	X			X			X			X	N/A	N/A	X	N/A	N/A
ID	X	1	N/A	X	15		X	4			3	N/A	X		
IL				X											
IN		15		X	20		X	27		X	20	N/A	X	7	N/A
IA	X	71	2395	X	27	485	X	8	N/A	X	16	N/A	X	18	N/A
KS	X						X			X	N/A	N/A	X (a)		
KY	X (k)	17	152	X	16	379	X	6		X					
LA	X						X			X			X		
ME	X	2	12	X	9	166	X	5	52	X	8	139	X	3	148
MD	X			X	4	494	X	6	336	X	29	811	X		
MA							X	5	163	X	47	1257	X	3	115
MI		1	N/A	X	29	N/A	X	22	N/A	X	63	N/A	X	19	N/A
MN	X (c, j)	4		X			X			X			X		
MS	X	54	N/A	X	12	N/A	X			X			X		
MO	X (j)	N/A	N/A	X	N/A	N/A	X	N/A	N/A	X	N/A	N/A	X	N/A	N/A
MT	X			X	35	N/A	X	4	N/A	X	4	N/A	X	4	N/A
NE	X	65	2123	X	15	274	X	2	115		11	904	X	10	321
NV	X	7	145	X			X (a)			X (a)					
NH	X	N/A	N/A				X	N/A	N/A	X	N/A	N/A			
NJ				(m)			X	N/A	N/A	X	N/A	1531			
NM	X	10	165	X	2	47	X	N/A	N/A	X	6	N/A		N/A	N/A
NY	(n)			(n)	50		X			X			X		
NC	X	22	1100	X	28	996	X	554	554	X	40	1288	X	14	651
ND	X			X			X			X			X		

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE II-2

MEDICAID COVERAGE FOR VARIOUS BED TYPES WITHIN GENERAL ACUTE CARE HOSPITALS

	SWING-BEDS			SKILLED NURSING			REHABILITATION			PSYCHIATRIC			ALCOHOL/DRUGS		
	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS	MEDICAID COVERAGE	# OF FACILITIES	# OF BEDS
OH					22	1138	X	21	470	X	76	2796	X (a)	43	1161
OK		6	54	X	9	360	X	25	232	X	11	310	X	21	217
OR	X (j, k)						X			X			X (a)		
PA					N/A	N/A	X	43	N/A	X	93	2949	X	8	233
RI	N/A			N/A			N/A			N/A			N/A		
SC	X	15	306	X	12	712		N/A	N/A		N/A	N/A		N/A	N/A
SD	X	39	N/A	X		N/A	X	2	N/A	X	3			2	
TN				X											
TX										X (a)	N/A	N/A	X (a)	N/A	N/A
UT	X	18	487	X	4	238	X (a)	3	N/A	X	7	N/A	X (a)		
VT	X	5	33	X	1	32	X	1	50	X	4	78	X	2	25
VA				X	12	375	X	9	485	X	N/A	N/A			
WA	X	20	N/A	X	11	365	X (a)	19	397	X	16	483	X (a)	N/A	N/A
WV				X	9	566		2	160		13	588			
WI							X (a)			X (a)			X (a)		
WY	X	13	163		2	43	X	2	N/A	X (a)	3	N/A	X (a)	2	N/A
Total	32			35			45			43			36		

KEY:

a. ACUTE-CARE COVERAGE ONLY.
b. MINIMUM EXPENDITURE THRESHOLDS
c. PARTICIPATION LIMITED TO SMALL HOSPITALS.
d. EXEMPT UP TO A MAXIMUM NUMBER OR PERCENTAGE OF HOSPITAL BEDS.
e. COVERAGE EFFECTIVE 1/1/90
f. ACCESSIBILITY VARIANCE.
g. ONLY NEW BEDS, NOT CONVERSIONS.
h. EXPEDITED CONVERSION PROCEDURE.
I. ONLY WHEN A NEW SERVICE.
j. LIMITED TO AREAS WITHOUT BEDS OF SIMILAR TYPE.
k. LIMITED TO A SET NUMBER PER HOSPITAL.
l. MORATORIUM ON NEW BEDS.
m. WHILE AWAITING NURSING HOME PLACEMENT.
n. NO, BUT COVERS A SIMILAR SERVICE.
o. CLASS OF HOSPITALS EXEMPT.
p. ALL NEW SERVICES.

NOTES:

N/A = NOT AVAILABLE

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, 1989

TABLE II-3

INPATIENT HOSPITAL USE AND EXPENDITURES
(Excluding Mental Health and Outpatient Departments)

1985 - 1988
Average Compound Rate of Growth

State	% Growth of Inpatient Expend.	% Growth of Total Inpatient Recipients	% Growth of Average Per Recipient Expend.
Alabama	3.4	-7.4	11.6
Alaska	11.9	10.7	1.1
Arkansas	5.9	5.6	0.33
California	7.2	2.9	4.2
Colorado	18.2	12.4	5.1
Connecticut	1.7	-0.5	2.2
Delaware	14.2	-0.4	14.6
District of Columbia	3.3	8.6	-4.8
Florida	27.9	27.8	0.1
Georgia	9.8	8.8	0.9
Hawaii	2.2	-3.8	6.2
Idaho	19.9	6.9	12.2
Illinois	-1.7	-4	2.3
Indiana	20.2	1.9	7
Iowa	13.5	7.4	5.7
Kansas	17.9	-5.8	25.2
Kentucky	5.2	-0.3	5.6
Louisiana	-4.2	-9.1	5.2
Maine	18.4	0.92	17.3
Maryland	11.6	6.3	5.2
Massachusetts	8.1	2.2	5.8
Michigan	4	2.5	1.5
Minnesota	5.7	1.1	4.5
Mississippi	21.8	5.3	15.6
Missouri	7.1	2.2	4.9
Montana	15.9	13.3	2.3
Nebraska	15.1	5.2	9.4
Nevada	19.4	13.5	5.2
New Hampshire	12.1	1.2	10.8
New Jersey	15.4	-0.8	16.3
New Mexico	10.3	6.3	3.9
New York	8.2	5.9	2.2
North Carolina	16.1	19.5	5.1
North Dakota	6.6	-3.6	10.5
Ohio	3.6	1.4	2.1
Oklahoma	9.5	7.6	1.8
Oregon	10.8	8.4	2.3
Pennsylvania	5.9	-1.3	7.3
Rhode Island	18.3	0.8	5
South Carolina	14.2	7.1	6.7
South Dakota	6.4	3.3	3
Tennessee	15.6	3.9	11.3
Texas	15.8	12.5	2.9
Utah	17.37	9.39	7.25
Vermont	7.2	-2.7	10.3
Virginia	16	5.3	10.2
Washington	12.3	9.1	2.9
West Virginia	21.3	5.6	14.9
Wisconsin	-0.9	-1.5	0.57
Wyoming	18.6	7.5	10.3
Average	**10.92**	**4.38**	**6.48**

SOURCE: HCFA-2082 REPORT

TABLE II-4

STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1988*
(Excluding Mental Health and Outpatient Departments)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.	% Growth in Avg. Per Recipient Expend.
Alabama	$81,520,393	46,108	$1,768	-10.8
Alaska	$24,496;119	4,052	$6,045	4.1
Arkansas	$88,513,030	55,119	$1,606	-4.6
California	$1,861,818,981	514,960	$3,615	9.2
Colorado	$77,279,206	30,704	$2,517	-3
Connecticut	$120,447,360	38,960	$3,092	1.5
Delaware	$22,597,413	5,858	$3,858	0.5
District of Columbia	$122,419,624	24,543	$4,988	-16.5
Florida	$441,354,121	136,242	$3,239	6.3
Georgia	$280,333,830	124,841	$2,246	2.1
Hawaii	$35,968,687	11,289	$3,186	24.5
Idaho	$24,618,643	7,209	$3,415	32.8
Illinois	$555,418,764	174,496	$3,183	1.2
Indiana	$218,807,617	64,113	$3,413	6.3
Iowa	$112,342,693	38,506	$2,918	23.2
Kansas	$73,719,360	20,550	$3,587	49
Kentucky	$173,304,403	76,180	$2,275	8.5
Louslana	$136,640,389	63,596	$2,149	13.4
Maine	$79,306,982	28,953	$2,739	-33.7
Maryland	$253,022,485	81,318	$3,112	4.9
Massachusetts	$492,240,463	114,974	$4,281	-8.6
Michigan	$497,262,583	147,224	$3,378	-4.7
Minnesota	$164,767,230	54,184	$3,041	-1.6
Mississippi	$108,884,485	71,333	$1,526	17.1
Missouri	$143,876,824	71,161	$2,022	4.6
Montana	$29,571,790	11,783	$2,510	7.3
Nebraska	$50,505,329	19,757	$2,556	5
Nevada	$25,822,812	6,793	$3,801	11.2
New Hampshire	$18,843,677	6,548	$2,878	0.41
New Jersey	$443,852,981	83,220	$5,333	33.6
New Mexico	$62,339,423	20,873	$2,987	10.9
New York	$2,232,282,165	387,434	$5,762	10.2
North Carolina	$252,517,068	97,789	$2,582	7.7
North Dakota	$23,631,729	8,705	$2,715	4.8
Ohio	$558,720,160	184,264	$3,032	5.1
Oklahoma	$162,840,396	58,114	$2,802	16.5
Oregon	$45,208,059	28,023	$1,613	29.8
Pennsylvania	$434,457,714	167,086	$2,600	11.3
Rhode Island	$101,224,131	15,532	$6,517	7.8
South Carolina	$100,201,736	77,369	$1,295	12.2
South Dakota	$23,756,490	8,645	$2,748	2
Tennessee	$182,946,659	100,416	$1,822	-15.3
Texas	$417,097,672	224,215	$1,860	3
Utah	$46,595,588	15,404	$3,025	5.9
Vermont	$19,379,472	7,001	$2,768	1.7
Virginia	$165,462,165	65,433	$2,529	13.8
Washington	$178,955,742	54,055	$3,311	26.2
West Virginia	$102,879,247	40,652	$2,531	-1
Wisconsin	$127,587,224	57,020	$2,238	-7.9
Wyoming	$12,298,303	3,649	$3,370	15.4
SUMMARY:	**$ TOTAL:**	**TOTAL:**	**AVG $:**	**AVG GROWTH:**
	$12,009,939,417	**3,756,253**	**$3,048**	**6.87**

*** All dollar amounts refer to both federal and state money.**

TABLE II-2

SOURCE: HCFA-2082 REPORT

TABLE II-5

STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1987*
(Excluding Mental Health and Outpatient Departments)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.	% Growth in Avg. Per Recipient Expend.
Alabama	$69,169,961	34,887	$1,983	41.8
Alaska	$22,325,445	3,832	$5,826	-5.8
Arkansas	$81,313,254	48,288	$1,684	-12.7
California	$1,672,814,388	505,560	$3,309	4.9
Colorado	$60,816,232	23,431	$2,596	7.4
Connecticut	$113,466,135	37,261	$3,045	1.2
Delaware	$22,180,600	5,791	$3,830	35.7
District of Columbia	$128,518,770	21,497	$5,978	-11.6
Florida	$338,463,753	110,839	$3,054	13.1
Georgia	$231,287,185	105,178	$2,199	-3.9
Hawaii	$28,907,784	11,306	$2,557	-3.5
Idaho	$15,601,984	5,981	$2,609	2.7
Illinois	$551,733,461	171,220	$3,222	9.2
Indiana	$192,101,360	64,203	$2,992	0.26
Iowa	$87,929,169	37,153	$2,367	-2.3
Kansas	$54,804,533	22,770	$2,407	7.4
Kentucky	$160,873,387	76,773	$2,095	11.8
Louisiana	$161,299,237	85,142	$1,894	-0.78
Maine	$76,411,767	18,484	$4,134	9.6
Maryland	$232,315,876	78,373	$2,964	7.6
Massachusetts	$503,752,903	107,468	$4,687	2.8
Michigan	$567,107,125	159,893	$3,547	-2.7
Minnesota	$136,548,541	44,141	$3,093	7.3
Mississippi	$92,706,043	71,132	$1,303	22.4
Missouri	$130,904,860	67,726	$1,933	20.2
Montana	$27,748,946	11,862	$2,339	-2.7
Nebraska	$50,674,013	20,822	$2,434	21.7
Nevada	$22,284,486	6,519	$3,418	5.6
New Hampshire	$16,999,747	5,932	$2,866	11.1
New Jersey	$380,729,611	95,449	$3,989	7.4
New Mexico	$51,023,088	18,950	$2,693	2.6
New York	$2,103,152,603	402,418	$5,226	-14.9
North Carolina	$205,140,535	85,574	$2,397	4.9
North Dakota	$22,389,657	8,649	$2,589	48.3
Ohio	$608,520,728	210,892	$2,885	-5
Oklahoma	$139,072,114	57,834	$2,405	34.6
Oregon	$33,254,443	26,785	$1,242	-6.2
Pennsylvania	$409,486,604	175,421	$2,334	-1.7
Rhode Island	$91,055,819	15,067	$6,043	7.3
South Carolina	$109,629,751	74,347	$1,475	0.82
South Dakota	$23,231,466	8,626	$2,693	2.9
Tennessee	$193,565,535	89,935	$2,152	3
Texas	$381,820,180	211,511	$1,805	-2.5
Utah	$43,244,245	15,152	$2,854	2.9
Vermont	$19,319,383	7,101	$2,721	14.2
Virginia	$139,719,915	62,906	$2,221	10.9
Washington	$175,980,330	67,098	$2,623	3.6
West Virginia	$95,458,290	37,330	$2,557	19.5
Wisconsin	$143,267,220	58,938	$2,431	11.1
Wyoming	$16,480,290	5,643	$2,920	7.3
SUMMARY:	**$ TOTAL:**	**TOTAL:**	**AVG $:**	**AVG GROWTH:**
	$11,236,602,752	**3,699,090**	**$2,892**	**6.98**

*** All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1986*
(Excluding Mental Health and Outpatient Departments)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.	% Growth in Avg. Per Recipient Expend.
Alabama	$80,157,879	57,323	$1,398	9.9
Alaska	$17,983,226	2,906	$6,188	6.1
Arkansas	$96,713,284	50,117	$1,930	21.1
California	$1,478,305,383	468,960	$3,152	1.3
Colorado	$31,578,820	13,067	$2,417	11.4
Connecticut	$123,634,155	41,078	$3,010	3.9
Delaware	$17,321,497	6,137	$2,822	10.2
District of Columbia	$111,866,765	16,523	$6,770	17
Florida	$262,311,448	97,168	$2,700	16.3
Georgia	$220,542,364	96,453	$2,287	4.7
Hawaii	$30,559,567	11,533	$2,650	-4.5
Idaho	$15,623,640	6,152	$2,540	4.9
Illinois	$558,080,434	189,298	$2,948	-0.97
Indiana	$181,046,160	60,656	$2,985	7.2
Iowa	$74,748,784	30,856	$2,423	2.6
Kansas	$36,549,540	16,309	$2,241	22.6
Kentucky	$140,350,149	74,930	$1,873	3.2
Louisiana	$167,518,223	87,767	$1,909	3.4
Maine	$75,831,116	20,113	$3,770	55
Maryland	$206,004,316	74,839	$2,753	2.9
Massachusetts	$506,027,233	111,074	$4,556	25.9
Michigan	$591,811,521	162,206	$3,649	13
Minnesota	$126,608,577	43,956	$2,880	8.1
Mississippi	$75,209,544	70,674	$1,064	7.8
Missouri	$115,465,019	71,797	$1,608	-8.3
Montana	$25,534,041	10,617	$2,405	2.5
Nebraska	$40,756,148	20,380	$2,000	2.5
Nevada	$20,917,673	6,467	$3,235	-0.8
New Hampshire	$15,557,936	6,033	$2,579	21.8
New Jersey	$316,974,220	85,346	$3,714	9.3
New Mexico	$48,095,094	18,328	$2,624	1.6
New York	$2,019,534,277	328,668	$6,145	13.6
North Carolina	$193,523,334	84,675	$2,285	2.6
North Dakota	$19,085,278	10,938	$1,745	13.3
Ohio	$572,571,308	188,505	$3,037	6.7
Oklahoma	$109,796,153	29,837	$3,680	38.6
Oregon	$34,496,851	26,032	$1,325	-7.1
Pennsylvania	$422,020,135	177,652	$2,376	12.8
Rhode Island	$79,940,556	14,207	$5,627	0.26
South Carolina	$107,914,309	73,777	$1,463	37.1
South Dakota	$21,404,814	8,185	$2,615	4.2
Tennessee	$182,520,165	82,198	$2,220	11.5
Texas	$342,499,882	184,952	$1,852	8.7
Utah	$34,081,285	12,299	$2,771	13
Vermont	$16,768,180	7,043	$2,381	15.3
Virginia	$122,312,010	61,085	$2,002	6
Washington	$128,897,019	47,338	$2,723	10.4
West Virginia	$73,405,906	34,314	$2,139	28.1
Wisconsin	$112,194,062	51,276	$2,188	0.5
Wyoming	$9,854,467	3,624	$2,719	8.1
SUMMARY:	**$ TOTAL:**	**TOTAL:**	**AVG $:**	**AVG GROWTH:**
	$10,412,503,747	**3,455,668**	**$2,807**	**10.11**

*** All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

TABLE II-7

STATE MEDICAID INPATIENT HOSPITAL EXPENDITURES FOR 1985*
(Excluding Mental Health and Outpatient Expenditures)

State	Inpatient Expenditure	Total Inpatient Recipients	Average Per Recipient Expend.
Alabama	$73,847,525	58,095	$1,271
Alaska	$17,483,241	2,989	$5,849
Arkansas	$74,542,961	46,875	$1,590
California	$1,509,936,841	472,420	$3,196
Colorado	$46,821,625	21,600	$2,168
Connecticut	$114,533,761	39,536	$2,897
Delaware	$15,193,444	5,932	$2,561
District of Columbia	$110,802,341	19,153	$5,785
Florida	$210,814,201	65,286	$3,229
Georgia	$212,013,490	97,075	$2,184
Hawaii	$33,731,942	12,672	$2,662
Idaho	$14,290,682	5,905	$2,420
Illinois	$585,428,882	197,144	$2,970
Indiana	$168,607,996	60,556	$2,784
Iowa	$76,901,151	31,088	$2,474
Kansas	$44,914,590	24,587	$1,827
Kentucky	$148,756,604	76,908	$1,934
Louisiana	$156,490,747	84,711	$1,847
Maine	$47,767,873	28,168	$1,696
Maryland	$180,812,021	67,640	$2,673
Massachusetts	$389,914,137	107,816	$3,616
Michigan	$441,961,618	136,907	$3,228
Minnesota	$139,547,390	52,423	$2,662
Mississippi	$60,273,800	61,051	$987
Missouri	$117,026,742	66,707	$1,754
Montana	$18,998,044	8,101	$2,345
Nebraska	$33,141,303	16,994	$1,950
Nevada	$15,159,228	4,645	$3,264
New Hampshire	$13,369,683	6,319	$2,116
New Jersey	$289,018,338	85,131	$3,395
New Mexico	$46,393,668	17,396	$2,667
New York	$1,762,284,543	326,038	$5,405
North Carolina	$161,571,650	72,593	$2,226
North Dakota	$19,533,678	9,702	$2,013
Ohio	$503,233,256	176,836	$2,846
Oklahoma	$123,998,203	46,720	$2,654
Oregon	$33,213,121	22,007	$1,509
Pennsylvania	$365,568,839	173,574	$2,106
Rhode Island	$79,710,349	15,173	$5,253
South Carolina	$67,244,399	63,013	$1,067
South Dakota	$19,698,425	7,850	$2,509
Tennessee	$118,392,332	89,489	$1,323
Texas	$268,172,533	157,439	$1,703
Utah	$28,856,582	11,769	$2,452
Vermont	$15,711,394	7,610	$2,065
Virginia	$105,905,697	56,081	$1,888
Washington	$126,512,619	41,606	$3,041
West Virginia	$57,586,074	34,506	$1,669
Wisconsin	$131,292,836	59,672	$2,200
Wyoming	$7,374,384	2,934	$2,513
SUMMARY:	**$ TOTAL:**	**TOTAL:**	**AVG $:**
	$9,404,356,783	**3,356,442**	**$2,569**

*** All dollar amounts refer to both federal and state money.**

SOURCE: HCFA-2082 REPORT

III. TARGETED CASE MANAGEMENT AS AN OPTIONAL SERVICE

On April 7, 1986, Section 9508 to the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) entitled, "Optional Targeted Case Management Services" gave states the statutory authority to provide case management under Medicaid through a state plan amendment. This law added subsection (g) to section 1915 of the Social Security Act.

In Section 1915 (g) (2) of the Act, case management is defined as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services." This definition gives states much flexibility as to what services they can offer as case management. Although final regulations have not been promulgated, the Health Care Financing Administration (HCFA) has offered some guidelines for adding targeted case management. When submitting a state plan amendment, the state must identify the population to which services will be provided, establish its own service definitions, decide who can provide the service, establish payment methods and rates, and can set limits on the amount, duration and scope of the service. A separate amendment should be submitted for each "target" group.

The state plan amendment cannot restrict free choice of providers or restrict other Medicaid services. The freedom of choice requirement ensures that any person who meets the qualifications established by the state must be given the opportunity to become a provider. In addition, case management cannot restrict access to other services available under the state plan. The plan amendment must ensure that payments for case management services do not duplicate the payments made to public and private entities for the same purpose.

States have the option of waiving two general Medicaid statutory requirements: statewideness and comparability. If statewideness is waived the state must identify which geographic locations are to receive the case management services.

The guidelines also distinguish which services can be considered case management and which cannot. For example, a referral or arrangement for treatment can be case management but the actual treatment is not. Other services which cannot be reimbursed as a case management service are administrative activities which are necessary for the proper and efficient administration of the state plan (such as eligibility determinations, preadmission screening, etc.) Institutional discharge planning and client outreach are not case management services.

Since enactment of COBRA, amendments to the enabling legislation have been added. Provisions to the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) allow states to target individuals with AIDS or AIDS-related conditions and individuals with developmental disabilities or with chronic mental illness.

This amendment has little impact on states' flexibility, however. Provisions of OBRA-87, on the other hand, give states the statutory authority to restrict to certain providers those who can deliver case management to the mentally retarded/developmentally disabled and chronically mentally ill. For these populations, then, states can designate who the case managers will be and pay only those who are designated as case managers.

In April 1988 the National Governors' Association (NGA) received responses to a survey sent to all fifty states and the District of Columbia regarding state plan amendments adding case management as an optional service. Since that time NGA has monitored state's adoption of the targeted case management option through the State Medicaid Information Center (SMIC). The information submitted to NGA from the survey and through SMIC is displayed on the following table. As of December 1989 thirty-four states are providing targeted case management. Eighteen states are offering case management services to two or more separate target populations.

The chronically mentally ill (CMI) is the population most often targeted, with seventeen states offering case management services. Sixteen states provide case management to the mentally retarded/developmentally disabled (MR/DD) population. Fourteen states provide case management services to different targeted children populations. Examples of these include children with developmental delays, ventilator assisted, disabled, medically fragile, and emotionally disturbed. Other groups targeted include pregnant women, the aged and disabled, and HIV-infected individuals.

Case management providers are most often individuals who have experience with the targeted population. According to information submitted to NGA, registered nurses (RN) and social workers (SW) are the professionals most frequently hired by states as providers. However, states require a wide range of education and experience of their providers. Some states, Georgia and Vermont, for example, contract with local agencies to provide case management.

As with other Medicaid services, states are free to establish limits on amount, duration and scope of service. The limits on case management set by states are listed on the survey table. States set limits on the maximum or minimum number of services and require the provider to receive prior authorization. In Missouri, for example, a case manager must get prior authorization and must provide at least one case management service per month to the pregnant woman.

The reimbursement methodology varies from state to state as well. The methodology most often used is fee for service. A few states use capitation. Some states pay more for the initial services which involve more of the case manager's time. Georgia, for example pays $3.90 a day for the first six months and $3.36 for each day thereafter. Maine and Maryland use a similar reimbursement methodology. Another example of variable payment rates is when the target group or service differs. For example, North Carolina will pay $148 per month for case management services to a CMI child and less, $111 per month, for the services to a CMI adult. In Rhode Island if the CMI individual is community-based the payment is more ($18.5 per every half hour) than if the recipient is a group resident ($13 a day). Washington also uses this methodology for two of its plan amendments.

In addition to Section 9508 of COBRA, states have the option of providing case management services through other statutory authorities. Section 1915 (b), (c), and (d) of the Social Security Act allows for case management to be covered through waivers. Under a Section 1915 (b) waiver the state can waive the freedom of choice requirement in order to implement a "primary care case management system."

This brief report has described states' plan amendements adding case management as an optional service. For additional information please see "Issue Brief: Case Management as an Optional Medicaid Service: Initial State Responses," prepared by John Luehrs, Director of Health Policy Studies, National Governors' Association.

For further information, call Janine Breyel at 202-624-5851.

TABLE III-1

TARGETED CASE MANAGMENT AS AN OPTIONAL SERVICE

	STATUS	TARGETED GROUPS	LIMITS	WAIVED		PROVIDERS	PAYMENT
				S'WIDE	COMP.		
AL	P	MR/DD, CMI, 22 years or older.			X	BA, BS, or RN	
	P	Handicapped children age 0-21			X		
	P	Pregnant women			X		
	P	HIV-infected individuals			X		
AK	N						
AZ	N						
AR	A	Pregnant women	1 unit/month		X	MDs, RNs, SWs	$8-10/month
CA	D						
CO	N						
CT	N						
DE	D 5/89	Pregnant women			X	RN,SW, RD/Nutr.	
DC	N						
FL	A 4/87	Disabled children, handicapped individuals who previously received Children's Medical Services.					
GA	A 10/87	CMI, MR/DD, Substance Abusers	Prior auth.	X		Contracts with special local providers.	$3.90/day, 1st 6 mos. $3.36/day after
HI	No resp.						
ID	N						
IL	N						
IN	P	Pregnant women		X	X		
IA	7 / 88	Pregnant Women		X	X	RN, SW	
	A 1/89	CMI, MR/DD			X	State or county.	Monthly rate per recipient.
KS	A 7/88	CMI	100 hrs. per yr. per rct.			Community health ctrs.	$30/hr.
	7 / 88	Ventilator-dependent children			X		
	10 / 89	Severely emotionally disturbed children & adolescents.			X		
KY	N						
LA	A 10/86	Individual 21 or younger who is ventilator assisted.	1604 units/yr. Unit = 15 min.		X	Prior exp. & assoc. with hospital	Reasonable cost.
ME	A 10/86	MR/DD	No.		X	BA and 3-4 yrs. exp.	$23.26/week
	A	CMI	No		X	MSW, Psych RN w/MS.	$204/first wk.; $34.80/wk. after
	A	Children with developmental delays.	No		X	RN, MSW, psychologist.	Not determined
	7 / 89	HIV-infected individuals			X	SW, RN	$28.04 per week
MD	A 7/87	Aged, anyone seeking nursing home admission.	Min. of 1 call or visit per month.				$90/1st 60 days, $15/30 day after
	P	HIV-infected individual					
	7 / 88	Pregnant adolescents 18 and under, or at risk of pregnancy.			X	SW	
MA	A 8/87	Enrollees in 1) preferred physician program (PPP); 2) prepaid medical care program (PMCP); and 3) high-cost case management (HCCM)			X	PPP-MD; PMCP-MD; HCCM-RN, discharge planner, MD	PPP-non reimburse. PMCP-capitated HCCM hourly
	7 / 88	CMI					
	10 / 88	MR					
MI	A 4/86	CMI & MR/DD	1 per month		X	QMRP, QMHP	Fee for service.
		A/D	1 per month		X	RN	Fee for service.
		Medically fragile children	1 per month		X	RN	Fee for service.
		Elderly at-risk of institutionalization.	1 per month	X	X	RN	Fee for service.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, DECEMBER 1989

TABLE III-1

TARGETED CASE MANAGMENT AS AN OPTIONAL SERVICE

	STATUS	TARGETED GROUPS	LIMITS	WAIVED		PROVIDERS	PAYMENT
				S'WIDE	COMP.		
MS	A 10/88	High-risk pregnant women & infants			X	Physician, CNM, RN, MSW, BSW, RD/Nutr.	$48 - initial meeting, $11.55 - ongoing $12 - ongoing infants
MO	A 1/88	Pregnant women and children who are "at risk."	Prior auth. 1 per month		X	RN, Medical SW, MD, DO	$20/month
MT	N						
NE	A 4/1/87	MR age 18 or older.	Prior auth.		X	SW	Fee schedule
	A 1/87	A/B/D and AFDC-related groups.	Prior auth.		X	SW	Fee schedule
NV	N						
NH	A 10/87	CMI			X	SW	Reasonable cost
	A 10/87	Inds. meeting LOC criteria for an intermediate care facility & aprv'd for home- and com.-based serv.			X	SW	Flat rate
NJ	N						
NM	11 / 89	CMI		X	X	SW, RN	
NY	P	Pregnant, parenting, and at-risk for parenting adolescents, age 10-21					
	1 / 88	MR/DD in community, CMI			X		
NC	A 10/87	CMI, substance abusers.			X	Psychiatrist, psychologist, Pysch RN, MSW; RN	$148/mo. per child; $111/mo. per adult
	A 10/87	Pregnant women.			X	MSW, BSW, SW or RN	Fee-for-service
	A 10/87	Emotionally disturbed children & youth			X	BA, RN, QMNP	Fee-for-service
ND	N						
OH	4 / 88	CMI, MR/DD					
	4 / 88	Pregnant women			X	Phys., RN, SW, RD/Nutr.	Fee-for-service
OK	A 7/87	CMI	Provider must be employed at an agency.		X	Ind. w/degree & 1 yr. exp. w/target group	$14 per half hour
OR	7 / 89	DD			X		
PA	A 6/89	HIV-infected individuals			X	RN, MSW, BSW	Fee-for-service
RI	A 1/87	CMI	No	X	X	Mental health prof. or person w/ equiv. exp.	Com.-based: $18.5/.5 hr. Group res.: $13/day
SC	A 1/88	MR/DD	No		X	SW, QMRP, physicians	$79/month/recipient
SD	D,P						
TN	7/89	Pregnant women			X	RN, SW	$50/mo - initial $25/mo - ongoing
TX	10 / 89	CMI, MR			X		
UT	A 7/87	Individuals under age 21 under statutory responsibility of Social Serv. Dept., physically & mentally handicapped individuals age 18 or older.	No		X	Psychologist, SW social services worker.	Fee-for-service
	A 1/88	Pregnant women			X	RN, SW	$15/month
VT	A 10/87	CMI				CMHC	$25/hour
	7 / 88	MR			X		
VA	A 7/88	High risk pregnant women, and children to age 1.	Prior auth. from Medicaid		X	RN, SW	Fee-for-service

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, DECEMBER 1989

TABLE III-1

TARGETED CASE MANAGMENT AS AN OPTIONAL SERVICE

	STATUS	TARGETED GROUPS	LIMITS	WAIVED		PROVIDERS	PAYMENT
				S'WIDE	COMP.		
WA	A 3/87	Persons with AIDS.			X	Masters' degree in related field.	Capitated
	A 6/87	All Medicaid recipients under age 21 whose family/caretaker needs asst. in obtaining services for child.			X	Paraprofessional, RN, MSW, Masters' degree	$85/mo. - 1-child fam. $95/mo. - 2-or-more
	A 7/87	Pregnant and parenting teens.			X	Paraprofessional, RN MSW, Masters' degree	$85/mo. if no children; $95/mo. with children
WV	A 4/87	CMI, MR/DD	No		X		Fee schedule
WI	A 10/87	CMI, MR/DD, A/D, severely emotionally distrubed children, persons with Alzheimers, substance abusers.	1 case assessmt. per yr.; 1 case plan per year.	X	X	BA in human resources plus exp.	$20/hour
WY	N						

KEY:

Under "Status"

A = Approved state plan amendment adding case managment as an optional service. (If approved, then the effective date is included.)
D = State plan amendment was disapproved.
N = No state plan amendment
P = Decision on state plan amendment is pending.

Under "Targeted Groups"

A/B/D = Aged, Blind, and Disabled
A/D = Aged and Disabled.
CMI = Chronically Mentally Ill
MR/DD = Mentally Retarded/Developmentally Disabled

Under "Waived"

An "X" in the S'WIDE column indicates that the state disregarded Section 1902(a)(1), allowed under the COBRA provision for statewideness.

An "X" in the COMP column indicates that the state disregarded Section 1902(a)(10)(b) as allowed under the COBRA provision for comparibility.

Under "Providers"

CMHC = Community Mental Health Centers
DO = Doctor of Osteopathy
MD = Medical Doctor
MSW = Social Worker with Master's Degree
Pysch RN = Pyschiatric Registered Nurse
QMHP = Qualified Mental Health Professional
QMRP = Qualified Mental Retardation Professional
RD/Nutr. = Registered Dietician or Nutritionist
RN = Registered Nurse
SW = Social Worker

NOTE:

Information displayed in this table includes results from an April, 1988 survey and information submitted to NGA through the State Medicaid Information Project.

SOURCE: NATIONAL GOVERNORS' ASSOCIATION, DECEMBER 1989


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STATE PROFILES

The "State Profiles" section will be mailed to you under separate cover.


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I. SERVICES

1. GENERAL

A. Amount, Duration and Scope

HI *A 07/89 (+) Hawaii enacted a new law requiring medical coverage to public prison inmates who are eligible for medical assistance, and who have been determined to have a major illness or medical conditions requiring medical treatment outside the institution. Initially coverage will be limited to acute inpatient emergency room services. As of August 1, 1989, services will include outpatient hospital, physician, drug, lab/x-ray, vision, dental, rehabilitation, and other health care services covered under Medicaid. State funds pay for these services.

KS *A 01/90 (-) Kansas terminated MediKan, its state-only medical assistance program.

MT *A 02/89 ( ) Montana revised its swing-bed policy to allow swing beds in hospitals with 50 beds or less and reduced the mileage radius requirement from no appropriate nursing home beds available within 100 miles to within 25 miles.

SC *A 12/89 (+) South Carolina allows institutionalized individuals to deduct from their monthly recurring incomes certain medical expenses not covered by Medicaid or third party payers. Monthly recurring income is the amount of income that must be contributed toward institutional care costs. Allowable deductions include:

- o health insurance premiums;
- o prescription drugs over the 4 per month limit, not to exceed $12 per additional prescription;
- o eyeglasses not covered by Medicaid, up to $70 per occurrence for lenses, frames, and dispensing fee;
- o dentures, once per lifetime, up to $225 per plate or $450 for one full pair;
- o denture repair up to $37 per occurrence;
- o physician and other medical practitioner visits over the 18 visit per year limit, not to exceed $20 per visit;

- o hearing aids, once per lifetime, up to $380; and
- o other non-covered expenses up to $20 per item or service.

B. Utilization Controls

AR *A 01/90 (-) Arkansas added prior authorization as a requirement when performing cholecystectomy; hip, knee, or ankle replacement; transurethral resection; or prostate procedures.

HI *A 08/89 ( ) Hawaii increased its standard prior authorization period from 30 days to 60 days.

NJ *A 07/89 (-) New Jersey requires Medicaid patients enrolled in the Garden State Health plan to have all services except transportation, dental services and second opinion consultations prior authorized by the physician case manager.

NY *A 03/89 (+) New York revised its recipient restriction program (RRP) policy to allow an RRP recipient to be placed on a person's receipt of medical care, services, and supplies whether or not the person's Medicaid case is active. This change was adopted to reach reipients who were closing and re-opening their Medicaid cases to avoid RRP restrictions.

PA *A 12/89 (+) Pennsylvania imposed a 50 percent penalty for bypassing Place of Service Review (PSR). The PSR Program requires prior approval of elective admissions to hospitals short procedure units, and freestanding and ambulatory care centers.

C. Reimbursement

GA *B 01/89 (+) Georgia proposed increasing reimbursement for physician, nurse midwife, laboratory, radiology, and podiatry services by 7%. Certain obstetrical delivery procedures are to be increased by about 8%.

KY *A 07/89 (+) Kentucky revised rates for primary care facilities whose established rates on July 1, 1985 were below the median cost, and which currently have an actual cost per medical and nursing service above the median cost established on July 1, 1985. These facilities are now paid the median cost.

LA *A 02/89 ( ) Louisiana adopted a sliding fee schedule to standardize the method to charge for services/treatment through state facilities or programs, by using the federal poverty income guidelines as a basis for determining eligibility for assistance or services.

MI *A 02/89 (+) Michigan increased reimbursement levels 0.5% for all fee-for-service providers except health maintenance organizations, hospice, pharmacy, and long term care. The increase will be applied across the board for all affected providers except orthotist/prosthetist, medical supplier, and shoe stores where select procedures will be adjusted for an overall average increase of 0.5%. Reimbursement will be made at the lesser of fee screen or provider charge.

MN *A 07/89 ( ) Minnesota removed the historical individual usual and customary charge for payment, and began paying the lower of the submitted charge at the 50th percentile or prevailing charges in 1982 for the following services: physician, dental care, vision care, podiatric, chiropractic, physical therapy, occupational therapy, speech pathology, audiology, mental health center, psychological, public health clinic, and indepdendent laboratory and x-ray.

NE *A 08/89 (-) Nebraska changed reimbursement for physician and other non-institutional practitioners to a fee schedule developed from a relative value scale.

OH *A 04/89 (+) Ohio increased the following fees in addition to the 2% increase which was effective January 13, 1989, because additional funds became available.

- -Most practitioner services (as well as the pharmacy dispensing fee, ambulance services, and home health services) rendered on a fee-for-service basis increased by 1.5%.
- -Practitioner visits increased by 3%.
- -Dental sealants increased to $10 per sealant to promote preventive dental care.
- -Additional funds were allocated to address the disparity in reimbursement for brainstem evoked response testing, therapeutic radiology and delivery services.

OH *A 01/89 (+) Ohio increased fees for non-institutional services by 2% rather than the proposed 4% due to budgetary constraints.

OR *A 04/89 (-) Oregon reduced all practitioner fees including HMO/PCO (Primary Care Oregon) contracts by 2.02% with the exception of the drug dispensing fee.

WI *A 01/89 (-) Wisconsin increased copayments for the following services:

	3/1/88 Copayment	1/1/89 Copayment
Extensive and comprehensive office visits	$1.00	$2.00
Hospital admissions	$1.00	$3.00
Consultations	$1.00	$3.00
X-Ray Services (in a physician's office)	$1.00	$2.00
Diagnostic Tests (in a physician's office)	$0.50	$1.00
Laboratory Services (in a physician's office)	$0.50 per service	$1.00

At the same time, the copayment for subsequent hospital visits was eliminated.

OK *A 02/89 (-) Oklahoma limited adult inpatient hospital days to 20 per year. Inpatient hospital days for children under 21 were limited to 60 per year, with exceptions granted for approved catastrophic illnesses.

OR *A 07/89 (+) Oregon makes deductible and coinsurance payments on QMBs' and other dual-eligibles' non-Medicaid services up to Medicaid payment levels.

OR *A 07/89 (+) Oregon dropped coverage of 12 hospital inpatient days for children in foster care who are not Medicaid eligible. In September, the inpatient days were reinstated along with an additional 6 days, for a total of 18 days for this group.

OR *A 07/89 (+) Oregon now reimburses family planning clincs for an annual family planning visit, pregnancy test visit, pap smear, and infection/disease visit.

SC *A 09/89 ( ) South Carolina revised the nursing home bed policy to follow Medicare's policy of canvassing a 50-mile radius for a bed, rather than the whole state.

SC *A 04/89 (-) South Carolina expanded subacute care to include ventilator-dependent individuals determined by a hospital utilization review committee or the PRO to require nursing facility level of care. Hospitals, SNFs, and ICFs on contract with the Medicaid agency are paid $150 per day for this subacute care.

SC *A 03/89 (+) South Carolina added reconstructive breast surgery following a mastectomy. Prior authorization is required and is given when the reconstructive surgery is medically necessary.

TN *A 01/89 (+) Tennessee increased allowable inpatient hospital days for certain organ transplants, including heart, liver, and bone marrow.

WV *A 05/89 (-) West Virginia limited inpatient hospital days to 15. In September, the limit was increased to 25 days.

WV *A 04/89 (-) West Virginia limited hospital administratively necessary days to 30.

B. Utilization Controls

AR *A 01/90 (-) Arkansas added prior authorization as a requirement when performing cholecystectomy; hip, knee, or ankle replacement; transurethral resection; or prostate procedures.

AR *A 12/89 (+) Arkansas Medicaid now requires pre-certification for alcohol, chemical dependency, and psychiatric treatment admissions to a rehabilitative hospital. Pre-certification is only required if Medicaid is the primary payor.

CT *A 10/89 (-) Connecticut added prior authorization as a requirement for inpatient hospital admissions for dental services.

CT *A 06/89 (-) Connecticut added a hospital inpatient services utilization review program, naming it Connecticut Case Utilization Program (CONCUR). Reviews are conducted by the Connecticut Peer Review Organization.

FL *A 04/89 (+) Florida removed the prior authorization requirements for covered transplant procedures performed within the state in approved transplant centers. Covered transplant procedures performed out-of-state continue to require preadmission review.

ID *A 11/89 (-) Idaho now requires a PRO review of all hospital admissions.

IL *A 08/89 (-) Illinois limited prepayment reviews for hospitals participating in its selective contracting program to those determined to have had high-denial rates or prepayment reviews during the previous contract period.

KS *A 07/89 (-) Kansas began requiring preadmission certification for inpatient hospital stays for drug/alcohol treatment with the exception of detoxification admissions. To be certified, a documented need for drug/alcohol treatment and a medical or surgical condition requiring inpatient treatment are necessary. "Emergency" admissions for drug/alcohol treatment are not allowed.

MI *A 10/89 (-) Michigan added prior authorization as a requirement for impatient admissions and readmissions of GA recipients in Genes and Marquette Counties who are not enrolled in an HMO. For elective admissions, the call must be made prior to admission. For urgent or emergency admissions, the call must be made within one working day of admission.

MS *A 10/89 (+) Mississippi increased the inpatient hospital days to a maximum of 30 days per fiscal year for adults. Inpatient physician visits also were increased from 15 to 30 per fiscal year. When approved by the PRO children under age 21 are allowed unlimited inpatient days when in DSHs, and in non-DSHs for specified diagnoses. A $5 per day copayment is required in certain instances. For Medicare/Medicaid eligibles, Medicare deductibles are paid, but the allowable days are reduced to Medicaid lengths of stay.

MO *A 11/89 (-) Missouri contracted out preadmission review of non-emergency hospital admissions and post admission review of urgent and emergency hospital admissions. Exemptions to the preadmission review process include recipients enrolled in a Medicaid pre-paid health plan, recipients eligible for both Medicare and Medicaid, deliveries, and normal newborns.

NJ *A 04/89 (+) New Jersey requires hospitals to telephone Medicaid monthly with a patient count of those awaiting nursing home placement. Previously, hospitals submitted a monthly form indicating the number of such persons.

In order for a patient to be counted as awaiting placement, the patient must be determined as:

1. meeting the need for nursing care in either SNF or ICF;

2. medically ready to enter a nursing home, as determined by physician and/or utilization review This includes any patient who has exhausted the 10-day bed reserve requirement, is ready for discharge, and awaiting readmission to a LTC facility; and,

3. is interested in nursing home placement as opposed to home care.

NM *A 02/89 (-) New Mexico began requiring prior approval of patient transfers.

SC *A 09/89 (+) South Carolina placed subacute hospital care under its administrative days program. Reimbursement for subacute care remains the same, but the prior authorization requirement is removed.

SC *A 03/89 (-) South Carolina added the following utilization review services:

- o prior approval for all minor surgical procedures requiring inpatient hospitalization with 3 exceptions;
- o prior approval for elective inpatient or outpatient hysterectomies, lens extractions, nasal septal reconstructions, and coronary artery bypass procedures; and,
- o retrospective review of a random sample of paid hospital claims.

TN *A 05/89 (-) Tennessee restricted coverage for delivery of newborns to hospitals and ambulatory surgical treatment centers classified as maternity service providers. Exceptions are allowed for emergencies.

TX *A 09/89 (+) Texas increased payments to physicians and other providers by 3%. The legislature mandated this increase to restore a portion of its 10% reduction in physician reimbursement in 1986.

VT *A 12/89 ( ) Vermont adopted a new rule which details the conditions which must be met for coverage of cornea, kidney, heart, heart/lung, liver, and bone marrow transplants. The rule also addresses criteria to be met by transplant centers.

WA *A 01/89 (-) Washington established a second opinion program for certain elective surgical procedures. The program is two-part: a criteria review process and a second opinion consultation. The criteria review phase determines whether a second opinion consultation should occur, except that all hysterectomies, tonsillectomies, and adenoidectomies automatically require a second opinion.
The final decision to undergo or forego the surgery regardless of the result of the second opinion, remains with the patient.

C. Reimbursement

AL *A 06/89 (+) Alabama lifted its moratorium on new hospital beds, which had been established on October 1, 1983.

AL *A 01/89 (+) Alabama revised inpatient reimbursement to be the lesser of each hospital's customary charges or reasonable cost per day.

AL *A 01/89 (+) Alabama added liver transplant as covered only for children who qualify under the EPSDT program. Prior authorization is required. Payment will be made at 75% of charges up to a maximum payment of $125,000.

AR *A 01/89 (+) Arkansas established a specialized hospital reimbursement for rural hospitals with 99 or fewer licensed beds as of January 1, 1989, or with an average daily census of 50 patients or fewer during the preceding year.

CO *A 10/89 (-) Colorado added general acute care hospital psychiatric units to its prospective payment system. One claim is submitted for psychiatric and medical care supplied by the same hospital.

GA *B 01/90 (+) Georgia revised the cost outlier threshold amount for enrolled Georgia hospitals, other than free-standing children's hospitals. The new amount will be calculated using an average of charges for the 5 most expensive inpatient admissions in a hospital's base year, trended to the reimbursement year. The estimated annual cost of this change is $3,096,800.

GA *B 12/89 (-) Georgia proposed a revised reimbursement for participating non-Georgia hospitals. The depreciation and interest (capital cost) component of base period allowable costs will not be inflated by a trend factor in the calculation of prospective per-case rates for these hospitals.

This change is proposed to more accurately reimburse reasonable costs of inpatient hospital services provided by participating non-Georgia hospitals, in a manner consistent with reimbursement for enrolled Georgia hospitals. It is estimated that this change will result in annual savings of $575,900.

GA *B 01/89 ( ) Georgia proposed changing the criteria for designation of DSHs by adding an additional criterion: a hospital that has been designated a regional perimatal center.

IL *A 03/89 (+) Illinois initiated a pilot program to reimburse hospitals for extended stays when appropriate skilled nursing facility beds are not available. To be eligible a hospital must document its attempt to place the patient in at least five appropriate facilities. Reimbursement is limited to services provided after the minimum number of contacts have been made and reimbursement is not made for services which were billed as acute care and denied as not being medically necessary.

Two levels of care may be reimbursed:

1. If the patient's needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed, the rate is the average skilled statewide rate for skilled nursing care ($48.86).
2. If the level of care is not routinely performed within a skilled setting and the patient cannot be placed in a SNF because the level of care is unavailable, the rate is the average statewide negotiated rate for exceptional care ($123.00).

KS *A 07/89 (-) Kansas changed inpatient hospital reimbursement from per diem to DRG method. Medicaid/MediKan claims data was used to establish DRG weights.

KS *A 01/89 ( ) Kansas revised hospital swingbed rates to:

SNF - $44.93
ICF - $36.84

KY *A 08/89 (+) Kentucky began paying in-state disproportionate share hospitals at 125% of their uncapped Medicaid allowable per diem cost for medically necessary inpatient hospital services for recipients under age 1. Out-of-state hospitals designated as disproportionate share will be paid at 85% of the usual and customary actual billed charges for these services.

KY *A 01/89 (+) Kentucky adjusted its hospital reimbursement rates as follows:

PEER GROUP	1/1/88 UPPER LIMIT	1/1/89 UPPER LIMIT
0-50 Bed Size		
Median	$258.36	$305.13
120% of Median	$310.03	$366.16
51-100 Bed Size		
Median	$313.98	$376.63
120% of Median	$376.78	$451.96
101-200 Bed Size		
Median	$331.21	$354.56
120% of Median	$397.45	$425.47
201-400 Bed Size		
Median	$352.30	$411.74
120% of Median	$422.76	$494.09
401+ Bed Size		
Median	$460.71	$455.71
120% of Median	$552.85	$546.85
126% of Median	$580.49	$574.19
Mental Hospital (Including Psychiatric Facilities)		
Median	$218.47	$225.82
105% of Median	$229.39	
115% of Median	$251.24*	$259.69

* effective April 1, 1988.

MD *A 07/89 (+) Maryland reduced day limits for a number of DRGs. Hospitals are permitted to bill patients for extended stays. Patients denied services because of these changes may appeal. The reduced day limits are necessary in order to extend Medicaid to a greater number of pregnant women and infants.

MD *A 07/89 ( ) Maryland changed its hospital administrative day rate to $66.49 for FY 1990. This rate is equal to the average nursing home per diem rate.

MD *A 07/89 (-) Maryland lowered the hospital DRG day limits for state-only recipients to 60% of the average length of stay. Maryland will use the $7.2 million sav-

ings from this change to expand coverage for pregnant women and infants up to 185% of poverty. poverty.

MI *A 07/89 (+) Michigan revised reimbursement for hospital cost outliers as follows:

- o an episode is deemed to be a cost outlier when the operating costs for the episode (total charges for the episode times the hospital's operating cost-to-charge ratio) are more than 3 times the DRG payment amount for the episode;
- o when the inpatient episode does not meet the criteria for high or low day outlier status; and
- o when the recipient is less than one year of age (at the time of admission).

MI *A 04/89 (-) Michigan began reimbursing liver and pancreas transplants under a percent of charge methodology.

MI *A 02/89 (-) Michigan began using a standard rate as reimbursement for the operating costs of selected routine DRGs instead of using the hospital specific price. Payment will be the standard rate for the DRG adjusted by the area wage adjustor, the area nonlabor cost adjustor, an adjustor for each individual hospital's indirect eduction costs, and each hospital's indigent volume adjustor. Implementation of this policy is expected to decrease Medicaid expenditures by approximately $2 million annually.

MI *A 02/89 (+) Michigan increased fee screens by 0.5% for outpatient services, for DRG inpatient hospitals, and for prospective per diem inpatient hospitals.

MI *A 01/89 (-) Michigan began reimbursing high day outlier days at 80% of the DRG daily rate for children's hospitals and distinct part pediatric units with 150 or more beds.

MS *A 07/89 (+) Mississippi added unlimited inpatient hospital care and one inpatient physician visit per day for infants under one in disproportionate share hospitals. A disproportionate share hospital is one in which Medicaid days are 14% of total days.

MS *A 07/89 (+) Mississippi defined its standard deviation above the mean Medicaid inpatient utilization rate to be 25% for the classification of disproportionate share.

MO *A 01/90 (+) Missouri revised its DSH reimbursement policy. For such hospitals with either a paid to billed day ratio of less than 85%, or an unsponsored care ratio of at least 10%, Medicaid covers all medically necessary billed days of service for which the patient is Medicaid-eligible.

MT *A 09/89 ( ) Montana revised reimbursement to inpatient hospital providers for certified registered nurse anesthetist services using a reasonable cost basis.

MT *A 07/89 (+) Montana established a new base price per case for inpatient hospital admission. The rate was increased 3.9%, from $1,368.19 to $1,421.55.

NV *A 01/89 ( ) Nevada changed urban and rural hospital reimbursement to the following perspective rates:

DEFINITION	URBAN RATE	RURAL RATE
Newborn		
1 - 3 day stay	210	225
4 or more day stay	555	460
ICF/dat	100	100
SNF/day	125	125
Neonatal		
Day	655	-
ICF/day	100	-
SNF/day	125	-
Maternity		870
1 - 3 day stay	1,170	870
4 or more day stay	2,310	2,310
ICF/day	100	100
SNF/day	125	125
Med/Surgical		
1 - 5 day stay	2,160	1,530
6 - 10 day stay	4,020	2,855
11 - 15 day stay	8,1750	9,845
16 - 20 dqy stay	11,800	-
21 - 25 day stay	20,420	-
Per diem	555	630
ICF/day	100	100
SNF/day	125	125

NM *A 10/89 (-) New Mexico implemented a DRG inpatient prospective payment methodology. Two peer groups have been established to assist the 11 low-volume hospitals in the transition. These 2 additional peer groups (low-volume regional and low-volume community) will remain in effect until the next rebasing year.

NM *A 07/89 (+) New Mexico added an outlier adjustment to disproportionate share hospitals for cases involving $50,000 or more for individuals under age one. Payment will be at 80% of the hospital's standardized cost (cost to charge ratio).

NM *A 07/89 ( ) New Mexico amended its reimbursement methodology for inpatient hospital services by removing the differential operating cost ceiling for referral and by providing for the use of New Mexico specific relative values.

NM *A 06/89 (+) New Mexico adopted an outlier adjustment to disproportionate share hospitals for high-cost medically necessary inpatient hospital services for infaults. An outlier is defined as any case with $50,000 or more in billed charges. Payment is at 80% of the hospital's standardized cost (cost to charge ratio)

NM *A 01/89 ( ) New Mexico modified the methodology used to reimburse for inpatient hospital services for deliveries. The methodology breaks deliveries into three separate discharge rates: normal newborn, delivery, and all other. This will allow more equitable recognition of the costs and resources used to provided maternity care.

NM *A 01/89 (-) New Mexico implemented three diagnostic-related per discharge rates: delivery, normal newborn, and all other.

NY *A 01/89 ( ) New York increased the MAO applicants/recipients income and resource standards in January 1989 and January 1990 as follows:

MAO INCOME STANDARDS

NUMBER OF PERSONS	ANNUAL 1/89	ANNUAL 1/90	MONTHLY 1/89	MONTHLY 1/90
1	5,500	5,700	459	475
2	7,900	8,200	659	684
3	8,500		709	
4	10,200		850	
5	11,900		992	
6	13,600		1,734	

7	15,300	1,275
8	17,000	1 417

MAO RESOURCE STANDARDS

NUMBER OF PERSONS	RESOURCE STANDARD 1/89	1/90
1	3,250	3,350
2	4,950	5,100
3	5,750	
4	7,100	
5	7,950	
6	8,800	
7	9,650	
8	10,500	

OH *A 07/89 ( ) Ohio changed outlier methodology for selected inpatient hospital DRGs. Claims-grouping into these DRGs that qualify as both cost and day outliers will be paid as cost outliers.

OH *A 02/89 (+) Ohio increased its inpatient base rates and its capital and medical education add-on amounts by 11.9 percent to provide for estimated inflation and to adjust for differences between historically estimated and actual inflation.

OH *A 02/89 ( ) Ohio revised reimbursement policy on redetermination of peer group average cost per discharge. As of February 1989, if a redetermination results in a less than 1% change in the amount, the rate is not changed. If the change is between 1% and 5%, the rate is changed at the beginning of the next rate year. If the change is greater than 5%, the rate is changed and claims are adjusted during the rate year.

OR *A 01/90 (+) Oregon revised the cost outlier payment threshold to 300% of the DRG or $14,000 in costs. Cost outlier claims will be paid at 50% of costs above the threshold. The payment percentage may be deducted during the biennium as required to limit total payments to the amount approved by the legislature.

OR *A 07/89 (+) Oregon reimburses rural hospitals with fewer than 50 beds and less than 30 miles from another acute care hospitals at 100% of costs.

OR *A 07/89 (-) Oregon reduced Caesarean section reimbursement by $150.00.

OR *A 07/89 (+) Oregon increased the DRG unit value to $1883 for admissions.

OR *A 04/89 (-) Oregon dropped inpatient hospital benefits for GA clients, from 35% to 23% of the Medicaid DRG payment. This change is necessary due to budgetary constraints.

OR *A 01/89 (-) Oregon lowered the cost outlier reimbursement from 55% to 25% for inpatient hospital claims on January 1. On April 1, the reimbursement was reduced again to 0%. These adjustments were necessary in order to stretch funds through the end of the biennium, because the claims volume was higher than expected.

SC *B 10/89 ( ) South Carolina rebased its hospital rates effective October 1.

TX *A 09/89 (+) Texas increased its minimum standard dollar amount for hospital admissions from $1500 to $1600.

TX *A 09/89 (-) Texas revised reimbursement from per diem to DRG for individuals who are eligible for only a portion of their inpatient stay, and for individuals who exceed the 30-day inpatient limitation while registered as an inpatient.

TX *A 07/89 (+) Texas implemented an outlier payment to DSHs for exceptionally high-cost hospital care for infants. To qualify for a day outlier payment, inpatient days must exceed 2 standard deviations. Payment is based on the number of outlier days times 70% of full DRG per diem. The cost outlier threshold is the greater of the DRG payment times 1.5, prospective payment times 11.14. The actual cost outlier payment is calculated by subtracting the outlier threshold from the amount of reimbursement for the admission based on TEFRA principles and then multiplying the remainder by 70%. If an admission qualifies for both a day and a cost outlier, the outlier resulting in the highest payment to the hospital is made.

WA *A 11/89 ( ) Washington changed its payment method for hospital-based intensive care programs for clemical-using pregnant women from a DRG system to a percentage of charges.

3. OUTPATIENT HOSPITAL SERVICES

A. Amount, Duration and Scope

AL *A 01/90 (+) Alabama exempted laboratory and radiology services from the 3-per-calendar-year limitation on outpatient services.

CT *A 01/89 ( ) Connecticut removed its limitation restricting oral surgeries to inpatient and outpatient hospital settings. Oral surgeries may also be performed in office settings.

MI *A 02/89 (+) Michigan added medically necessary examinations to its outpatient hospital coverage.

MO *A 02/89 ( ) Missouri revised its policies on chlamydia culture and chlamydia test packs. A chlamydia test pack procedure was added as a reimbursable coverage in the physician office setting. Chlamydia cultures continue to be reimbursable only for laboratories and outpatient hospital settings. The fee for cultures was increased to $12.00.

MT *A 03/89 (+) Montana redefined outpatient physical therapy services to include therapy services not provided by a hospital or a home health agency. The outpatient physical therapy services limit has been revised from 70 visits per year to 70 hours per year; an additional 30 hours are allowed with prior authorization.

NV *A 09/89 (-) Nevada no longer reimburses for observation bed charges when a patient is admitted to the hospital or after out-patient surgery.

OR *A 07/89 ( ) Oregon revised the outpatient reimbursement rate to 69% of costs for services provided to Medicaid recipients. The GA reimbursement is 69% of costs or 50% of billed charges, whichever is less. Out-of-state hospitals receive 50% of billed charges.

OR *A 07/89 ( ) Oregon established a concurrent drug therapy review program for antiulcer therapy. The program also requires prior authorization of continuing antiulcer therapy.

B. Utilization Controls

CO *A 11/89 (-) Colorado added second opinion review as a requirement on outpatient surgical procedures. Previously a second surgical opinion was required for selected inpatient surgeries.

OR *A 01/89 (+) Oregon removed prior authorization for outpatient cataract surgeries. Prior authorization is still required for inpatient cataract surgeries.

SC *A 03/89 (-) South Carolina added the following utilization review services:

- o prior approval for all minor surgical procedures requiring inpatient hospitalization with 3 exceptions;
- o prior approval for elective inpatient or outpatient hysterectomies, lens extractions, nasal septal reconstructions, and coronary artery bypass procedures; and,
- o retrospective review of a random sample of paid hospital claims.

C. Reimbursement

GA *B 10/89 (-) Georgia proposed limiting reimbursement for dialysis services only under the dialysis services program. Maintenance dialysis would no longer be covered in the hospital program. Professional fees and facility reimbursement would be made at a flat rate per month. These changes are projected to produce annual savings of $1 million annually.

KY *A 07/89 (+) Kentucky increased the upper limits for the following outpatient services:

o psychosocial rehabilitation services (partial hospitalization)	$ 8.27
o outpatient (clinical)	14.15
o personal care (off-site)	3.09
o inpatient (off-site)	20.28

MI *A 02/89 (+) Michigan increased fee screens by 0.5% for outpatient services, for DRG inpatient hospitals, and for prospective per diem inpatient hospitals.

MN *A 07/89 (+) Minnesota implemented a facility fee schedule for outpatient hospital services.

OH *A 07/89 (-) Ohio implemented an outpatient payment system for all Ohio hospitals that are subject to the inpatient prospective payment system. Out-of-state hospitals and Ohio hospitals exempt from DRG reimbursement will continue to be paid for laboratory and radiology services on a fee-schedule basis, but will be subject to a fixed payment system for other outpatient services. As the system is phased in, a risk corridor will be operated to assure that aggregate payment for outpatient services other than lab and radiology will be no less than the lower of 80% of cost or total charges, and no more than the lesser of total costs or total charges. An adjustment will be made after each six months to bring payments within these parameters.

OR *A 07/89 (+) Oregon makes deductible and coinsurance payments on QMBs' and other dual-eligibles' non-Medicaid services up to Medicaid payment levels.

OR *A 07/89 (+) Oregon now reimburses family planning clincs for an annual family planning visit, pregnancy test visit, pap smear, and infection/disease visit.

4. HOSPITAL EMERGENCY ROOM SERVICES

A. Amount, Duration and Scope

MS *A 10/89 (-) Mississippi limited emergency room visits to 6 per fiscal year when a facility charge is made.

B. Utilization Controls

MS *A 09/89 (+) Mississippi removed the $1.00 copayment for minimal source office visits, emergency room visits, psychiatry sources, and specific opthalmological services.

5. RURAL HEALTH CLINIC SERVICES

A. Amount, Duration and Scope

ME *A 11/89 (+) Maine redefined homebound clients and their required treatment plans provided through rural health clinics. Homebound clients are confined to their place of residence because of a medical or health condition. Care is provided under a plan of treatment reviewed every 60 days. Rural health clinics may provide services to these individuals in their homes.

MD *A 10/89 (-) Maryland revised its free-standing clinic regulations to discontinue reimbursement for home visits to such clinics except for free-standing rural health clinics.

6. OTHER CLINIC SERVICES

A. Amount, Duration and Scope

CT *A 07/89 (+) Connecticut added neuropsychological evaluations as a covered mental health and rehabilitation clinic service. Neuropsychological evaluations are limited to one in any 12 month period per provider for the same recipient, and are reimbursed at $450.00.

GA *B 07/89 (+) Georgia proposed expanding the covered services available in ambulatory surgical centers to include sterilization, tonsillectomy, and adenoidectomy. The center must be Medicare certified, and reimbursement will be limited to the corresponding Medicare fee.

ME *A 11/89 (+) Maine revised ambulatory care clinic services to include providing primary health care. Such clinics now serve individuals of all ages.

MD *A 10/89 (-) Maryland revised its free-standing clinic regulations to discontinue reimbursement for home visits to such clinics except for free-standing rural health clinics.

MA *A 10/89 (+) Massachusetts added coverage of the following substance abuse treatment services:

- o free-standing inpatient drug detoxification;
- o methadone maintenance;
- o outpatient counseling, including individual and family therapies; and
- o acupuncture detoxification.

MN *A 07/89 (+) Minnesota added outpatient mental health services for children under its state-only EPSDT program.

MT *A 10/89 (+) Montana now allows public health departments to provide physician and nurse practitioner services.

MT *A 06/89 (+) Montana added coverage of family couseling when a Medicaid-eligible member of the family is determined to be in need of mental health services and is involved in the family therapy.

MT *B 06/89 (+) Montana limited mental health clinic services to individual therapy, family therapy, group therapy, emergency services, and day treatment. Reimbursement for mental health clinic services is based on the allowable rate for each service for state FY 85 plus 2%. The rates per 15-minute unit are:

individual therapy	- $14.30
day treatment	- $ 1.87
group/family therapy	- $ 3.58
emergency services	- $14.49

NY *A 11/89 (+) New York established an Intensive Care Management (ICM) Program. The program was developed as a mechanism to better serve the seriously and persistently mentally ill, who have not been well served by traditional mental health programs. The goals are to prolong community stays and avoid unnecessary or inappropriate hospitalizations.

WA *A 06/89 (+) Washington added drug detoxification as part of its detoxification program. Drug detoxification has a 5-day limitation.

B. Utilization Controls

NJ *A 12/89 (+) New Jersey increased the limit for mental health services from $600.00 to $800.00 within a 12-month period. Additional services may be covered with prior authorization.

TN *A 05/89 (-) Tennessee restricted coverage for delivery of newborns to hospitals and ambulatory surgical treatment centers classified as maternity service providers. Exceptions are allowed for emergencies.

C. Reimbursement

AR *A 01/89 (+) Arkansas changed End-Stage Renal Disease (ESRD) services charges to establish a fee schedule reimbursement methodology comparable to the Medicare rate.

CT *A 01/89 (+) Connecticut increased several mental health clinic fees. In general, these fees are approximately 55 percent of the statewide average of ususal and customary charges.

SERVICE DESCRIPTION	NEW FEE
Comprehensive service/physician	$27.50
Psychotherapy - ind. per treatment	19.25

Parent interview, child guidance clinics	35.75
Intellectual evaluation - ind.	68.75
Evaluation of aptitudes, interests, & educational adjustment	39.95
Family therapy	35.75

KY *A 07/89 (-) Kentucky reduced the mental health center funding adjustment of $1.55 per unit to $1.11 per unit.

KY *A 01/89 (-) Kentucky established a primary care center secondary upper payment limit for medical and nursing services set at 105% of the weighted median cost per visit. The secondary upper limit for providers who have a teaching component is set at 135%. However, as of January 1, 1990, this limit will be set at 120%, and as of January 1, 1991 and thereafter, this limit will be 105%.

KY *A 01/89 ( ) Kentucky established for primary care centers an incentive payment for providers with low medical and nursing costs. To qualify, providers must have medical and nursing costs in the lowest one-fourth of the array of such costs for their eligibility group at the beginning of the universal rate year. The incentive payment will be 20% of the average composite interim rate of the incentive eligible group. The initial incentive payment rate is set at $9.04, is prospective in nature, and is not subject to settlement after audit. Providers with up to 10,000 billable visits per year will receive incentive payments on an interim basis based on previous experience. These incentive payments are subject to a year-end settlement.

KY *A 01/89 ( ) Kentucky revised the methodology for determining primary care centers' interim rates using the most recent cost report available as of December 1, 1988 Prior rate setting will be used to set the interim payment. All costs are trended to the beginning of the universal upper limit year and indexed for inflation, using Data Resources Inc. forecasts, to the end of the upper limit year. The interim payment is a composite payment made as the result of a billable service being rendered.

KY *A 01/89 (+) Kentucky exempted newly participating primary care centers from upper payment limits until the agency has one full year of audited data resulting from Medicaid program participation.

MN *A 07/89 (+) Minnesota increased the public health clinic and community health clinic services payment rate by 20%.

7. PHYSICIAN SERVICES

A. Amount, Duration and Scope

AL *A 01/90 (+) Alabama increased the number of inpatient hospital days to 14 days per recipient, per calendar year. Additional days may be approved through prior authorization for EPSDT participants and for women with medically necessary days following a delivery.

AL *A 01/90 (+) Alabama increased from 12 to 14 the inpatient days of service per physician, per recipient, per calendar year to the already permitted 12 physician visits in offices, hospital outpatient settings, or nursing homes.

AL *A 12/89 (+) Alabama expanded its Maternity Waiver Program to three more counties. The program is designed to provide, through a single provider, a case managed, coordinated system of care to pregnant women.

CO *A 12/89 (+) Colorado dropped coverage of actinotherapy, the use of ultra violet light for treating chronic ulceration of the skin, if the primary diagnosis is one of the following:

- o decubitus ulcer;
- o ulcer of lower limb, except decubitus;
- o chronic uler of other spcicified sites; or
- o chronic uler of unspecified sites.

MI *A 02/89 (+) Michigan extended coverage to include services to recipients with tuberculosis regardless of their age.

MS *A 10/89 (-) Mississippi limited nursing home/swing bed physician visits to 36 visits per fiscal year.

MS *A 10/89 (+) Mississippi increased the inpatient hospital days to a maximum of 30 days per fiscal year for adults. Inpatient physician visits also were increased from 15 to 30 per fiscal year. When approved by the PRO children under age 21 are allowed unlimited inpatient days when in DSHs, and in non-DSHs for specified diagnoses. A $5 per day copayment is required in certain instances. For Medicare/Medicaid eligibles, Medicare deductibles are paid, but the allowable days are reduced to Medicaid lengths of stay.

MS *A 07/89 (+) Mississippi added unlimited inpatient hospital care and one inpatient physician visit per day for infants under one in disproportionate share hospitals. A disproportionate share hospital is one in which Medicaid days are 14% of total days.

MO *A 02/89 ( ) Missouri revised its policies on chlamydia culture and chlamydia test packs. A chlamydia test pack procedure was added as a reimbursable coverage in the physician office setting. Chlamydia cultures continue to be reimbursable only for laboratories and outpatient hospital settings. The fee for cultures was increased to $12.00.

MT *A 10/89 (+) Montana now allows public health departments to provide physician and nurse practitioner services.

NV *A 01/89 (+) Nevada expanded limits on a variety of outpatient services. Physician office visits increased from 2 visits to 5 visits per month with a maximum of 3 visits to one provider. Injections increased from 2 to 5 per month and prescription medication increased from 3 to 5 per month with a maximum 34 day supply.

PA *A 10/89 (-) Pennsylvania limited payment for nursing home/swing bed physician visits to 36 visits per fiscal year.

TX *A 09/89 (+) Texas eliminated its 30-day physician inpatient spell of illness limitation, which limited reimbursement of physicians and other providers to services provided during a 30-day inpatient stay.

B. Utilization Controls

MS *A 09/89 (+) Mississippi removed the $1.00 copayment for minimal source office visits, emergency room visits, psychiatry sources, and specific opthalmological services.

C. Reimbursement

CO *A 07/89 (+) Colorado increased reimbursement for obstetrical and infant care services.

IL *A 09/89 (+) Illinois increased rates for the following physician services due to additional funding made available through the budgetary and legislative processes.

- o Office visits increased 42%.
- o Laboratory services increased 5%.
- o Surgical pack rates, which are add-on amounts to the normal payment rate when the procedure is performed in the office setting, increased 20%.
- o Increased rates for prenatal delivery and postpartum care, which had been targeted to certain areas, were extended statewide.
- o All other physician services increased approximately 16.5%.

MS *A 07/89 (+) Mississippi increased fees for a number of physician services, including swing-bed follow-up, family planning visits, hospital care visits, antepartum and postpartum visits, normal newborn services, and opthalmological exams.

MT *A 07/89 (+) Montana increased physician reimbursement 2%.

NE *A 08/89 (-) Nebraska changed reimbursement for physician and other non-institutional practitioners to a fee schedule developed from a relative value scale.

OR *A 07/89 (+) Oregon increased by 2% all practitioner fees reduced as of April 1989, and added a 3.5% cost of living increase to these same services.

Oregon implemented a 4-tiered dispensing fee for pharmacy providers on Ocotber 16, 1989. The fee is based on total pharmacy dispensing volume and recent Medicaid dispensings, and is ranged between $3.56 and $3.90.

OR *A 07/89 ( ) Oregon revised physician hospital visit reimbursement rates to equal office visit rates.

OR *A 07/89 (-) Oregon reduced Caesarean section reimbursement by $150.00.

SC *A 07/89 (-) South Carolina increased physician reimbursement for visits and many commonly performed procedures, including intermediate office visits: from $25 to $30 for new patients and from $18 to $20 for established patients.

SC *A 07/89 (+) South Carolina began paying $100 for physical examinations, limited to 1 per recipient every 5 years, for adults age 21 and older.

TX *A 09/89 (+) Texas increased payments to physicians and other providers by 3%. The legislature mandated this increase to restore a portion of its 10% reduction in physician reimbursement in 1986.

8. NURSE PRACTITIONER, MIDWIFE, PHYSICIAN EXTENDER SERVICES

A. Amount, Duration and Scope

AL *A 01/89 (+) Alabama added prenatal office visits as a covered service for nurse midwives. This addition is limited to 6 or fewer office visits, so the nurse midwife will be able to bill for prenatal visits when total antepartum care cannot be given.

MD *A 07/89 ( ) Maryland began direct reimbursement to nurse anesthetists rather than indirect payment as part of hospital costs.

MT *A 10/89 (+) Montana now allows public health departments to provide physician and nurse practitioner services.

NM *A 09/89 (-) New Mexico added reimbursement to licensed midwives for a full range of services, including prenatal care, home delivery, and post-partum care. The fee for obstetric services, when provided by a licensed midwife, represents 77% of the Medicaid fee for obstetric services provided by a physician. In addition, midwives may bill for delivery supplies, venipuncture for a blood sample, a hematocrit, hemoglobin, and mileage in excess of 75 miles round trip for home visits.

SC *A 04/89 ( ) South Carolina began enrolling certified nurse midwives (CNMs) and paying them at 80% of the physician fee for delivery and 100% of the physician fee for antepartum and postpartum services. If the CNM bills through a physician, payment is made at 100% of the physician fee for all of the above services.

TN *A 07/89 (+) Tennessee added coverage of physician assistant services when ordered and billed by a physician.

B. Utilization Controls

KS *A 01/89 (+) Kansas now permits physician extenders to certify adult care home admissions. Previously, they were allowed to recertify adult care home stays.

C. Reimbursement

MT *A 09/89 ( ) Montana revised reimbursement to inpatient hospital providers for certified registered nurse anesthetist services using a reasonable cost basis.

OH *A 05/89 ( ) Ohio began reimbursing home health agencies and nurse-midwives directly for providing at-risk pregnancy services instead of requiring them to be under contract with another provider.

OH *A 04/89 (+) Ohio increased the following fees in addition to the 2% increase which was effective January 13, 1989, because additional funds became available.

- -Most practitioner services (as well as the pharmacy dispensing fee, ambulance services, and home health services) rendered on a fee-for-service basis increased by 1.5%.
- -Practitioner visits increased by 3%.
- -Dental sealants increased to $10 per sealant to promote preventive dental care.
- -Additional funds were allocated to address the disparity in reimbursement for brainstem evoked response testing, therapeutic radiology and delivery services.

OR *A 07/89 (+) Oregon increased the reimbursement rate for nurse practitioner services to the same rate as primary care physicians. Nurse practitioners also may be reimbursed for private duty nurse services if a separate provider number is used.

OR *A 07/89 (+) Oregon increased by 2% all practitioner fees reduced as of April 1989, and added a 3.5% cost of living increase to these same services.

Oregon implemented a 4-tiered dispensing fee for pharmacy providers on Ocotber 16, 1989. The fee is based on total pharmacy dispensing volume and recent Medicaid dispensings, and is ranged between $3.56 and $3.90.

9. OPTOMETRIST SERVICES

A. Amount, Duration and Scope

MS *A 07/89 (+) Mississippi began reimbursing optometrists for physician-type covered services authorized by the State Board of Optometry.

MT *A 01/89 (+) Montana expanded its definition of optometric services to include all services covered under this practitioners license.

NJ *A 03/89 (-) New Jersey added coverage of low vision examination following a comprehensive eye exam when vision in the better eye is 20/70 or less with best correction. Prior authorization of this service is required.

OR *A 12/89 (-) Oregon revised coverage of usual services as follows:

- o adults covered for 1 pair of glasses every 24 months, except 1 additional pair of glasses is covered within 120 days following cataract surgery;
- o children will be covered for services and materials with medically necessary documentation;
- o vision therapy sessions for children have been limited, but do not require prior authorization; and
- o low visual aids and some miscellaneous items will no longer be covered.

WI *A 09/89 (-) Wisconsin dropped certain vision care procedure codes, including disabled patient exams. The limited, intermediate, and complex follow-up consultation codes have been replaced by an office visit, limited service code.

WI *A 07/89 (-) Wisconsin revised optometrist vision care office visit policy by separating new patient visits from established patient visits. New patient visits can be reimbursed only once per patient per provider. For established patients, the minimal brief, limited, and intermediate visits may be reimbursed as often as medically necessary. One comprehensive visit and one low vision visit per year are allowed Prior authorization is not required, except for low vision visits and additional comprehensive visits. Supplemental tests may be billed with office visits

except that testing costs are considered covered in the reimbursement for a comprehensive or low vision office visit.

WI *A 07/89 (+) Wisconsin added certain optometric diagnostic and treatment procedures, including gonioscopy, additional tomometry procedures, opthalmoscopy procedures, diagnostic ultrasound, and electro-diagnostic services.

B. Utilization Controls

MI *A 10/89 (+) Michigan removed prior authorization for initial eye prostheses for specified diagnoses.

MS *A 09/89 (+) Mississippi removed the $1.00 copayment for minimal source office visits, emergency room visits, psychiatry sources, and specific opthalmological services.

NJ *A 03/89 (-) New Jersey added a prior authorization requirement for low vision work-up. A low vision work-up is much more detailed than a low vision examination following a complete comprehensive examination and requires a written report.

OR *A 01/89 (+) Oregon removed prior authorization for outpatient cataract surgeries. Prior authorization is still required for inpatient cataract surgeries.

C. Reimbursement

GA *B 01/89 (+) Georgia proposed increasing psychology and vision care services by 4%.

IL *A 09/89 (+) Illinois increased its rate for optometric examinations to $18.50.

KS *A 09/89 (+) Kansas increased the maximum allowable reimbursement for optical frames.

SC *A 07/89 (+) South Carolina added reconstructive breast surgery following a mastectomy. Prior authorization is required and is given when the reconstructive surgery is medically necessary.

10. DENTIST SERVICES

A. Amount, Duration and Scope

CT *A 10/89 (-) Connecticut revised the limitations of flouride treatment for children under 21 years of age to include 2 treatments per year in 6 month intervals.

CT *A 01/89 ( ) Connecticut removed its limitation restricting oral surgeries to inpatient and outpatient hospital settings. Oral surgeries may also be performed in office settings.

HI *A 07/89 (+) Hawaii added coverage of dental sealants for occlusal surfaces of patients age 6 through age 15.

KS *A 01/90 ( ) Kansas dropped a requirement that children under age three have a KAN Be Healthy (EPSDT) medical screen before receiving dental services.

KS *A 10/89 (-) Kansas dropped dental root removal for exposed roots and added simple extractions of a single tooth to one per quadrant.

KY *A 07/89 (+) Kentucky implemented a comprehensive orthodontia program that covers medically necessary treatment to correct handicapping malocclusions for recipients under age 21. Prior authorization of all services is required.

KY *A 07/89 (-) Kentucky dropped coverage of orthodontia services provided in primary care centers because these are specialty services, and inappropriate in a primary care center. Orthodontia services remain reimburseable through participating Medicaid dentists and orthodontists.

KY *A 05/89 ( ) Kentucky added a number of dental procedures in an effort to equalize coverage between dentists and oral surgeons.

ME *A 01/89 (+) Maine added serveral dental services for adults including:

- o composite restoration for all permanent teeth;
- o extractions necessary before surger, organ transplant, or chemo-therapy;
- o emergency treatment to reliev or eradicate acute pain;
- o fabrication and repair of dentures; and

- o complete diagnostic and treatment services for ICF/MR residents.

Routine dental care, periodontic treatment, and orthodontics remain uncovered services for adults (21 and over). Laboratory and X-ray services related to non-covered services are not reimburseable.

MD *A 06/89 (-) Maryland added coverage of assistant oral surgeon services for selected procedures performed in hospitals or Medicare-certified ambulatory surgery centers. The assistant oral surgeon must be a dentist. Maximum payment is 20 percent of the listed fee for the surgical procedure. Minimum payment is the lower of the dentist's fee or $25.

MI *A 10/89 (-) Michigan expanded its Wayne County County Care Program, a care management system that contracts with providers for services to General Assistance recipients in the county. Previously dentists were paid on a fee-for-service basis, but now the county has entered into a separate contract with a dental organization to provide service on a capitated basis.

OR *A 10/89 (-) Oregon reduced coverage of sealants under its dental program to children age 15 and under. Sealants are covered for permanent molars only.

OR *A 03/89 (+) Oregon set End Stage Renal Dialysis reimbursement at 80% of the Medicare maximum allowable charge.

SC *A 07/89 (+) South Carolina added the following dental services for recipients under age 21:

- o periodic oral exams once every 6 months;
- o prophylaxis once every 6 months;
- o topical fluoride once every 6 months;
- o two bitewings once every 6 months; and
- o six month recalls.

TN *A 05/89 (+) Tennessee began covering 1 dental diagnostic examination per recipient every six months.

TN *A 05/89 (-) Tennessee limited fluoride treatments, prophylaxis, and dental examinations to 1 each every 6 months. Tennessee also placed limits on radiographs and restorative services.

TX *A 11/89 (+) Texas added a dental program for ICF/MR residents age 21 and over who live in community-based facilities. The program includes emergency, preventive, therapeutic, and orthodontic services.

VT *A 01/89 (+) Vermont initiated limited dental coverage for Medicaid recipients age 21 and older.

B. Utilization Controls

AL *A 07/89 (-) Alabama added a prior authorization requirement for the following dental services:

- o out-of-state referral cases;
- o periodontal treatment;
- o hospitalization and/or general anesthesia for dental care;
- o home visits or treatment of a patient in a licensed medical institution; and,
- o orthodontic treatment.

CT *A 10/89 (-) Connecticut added prior authorization as a requirement for inpatient hospital admissions for dental services.

CT *A 01/89 ( ) Connecticut dropped prior authorization requirements for selected dental services including space maintainers, night guards, post and core, canal preparation, apicoectomy services performed in conjunction with a root canal, any combination of 3 or more extractions, all dental services for recipients who require ambulance transportation, all cases in which the dentist is requesting hospital inpatient or outpatient services, excision of exostosis, and retainer replacement.

KS *A 10/89 ( ) Kansas dropped prior authorization of partial denture relines for EPSDT recipients only, but added prior authorization of vertibuloplasty (ridge extensions).

MI *A 07/89 ( ) Michigan dropped prior authorization for selected oral surgery procedures. Some procedures now require an operative report and justification with the invoice.

OR *A 10/89 (+) Oregon revised reimbursement for several dental services for both adults and children. In addition most prior authorization requirements were removed.

C. Reimbursement

AL *A 07/89 (+) Alabama established reimbursement for dental and orthodontia clinics. Dental and orthodontia clinics administered by the Department of Public Health and Crippled Childrens Services are paid a fee for services not to exceed actual costs. Other dental and/or orthodontia clinics are reimbursed at their usual and customary fees, not to exceed the 75th percentile of the range of fees established by Medicaid.

AL *A 03/89 ( ) Alabama limited dental clinic reimbursement for public health department clinics to actual cost or the 75th percentile of the range of fees prevailing in the statewide profile. For other dental clinics reimbursement is limited to usual and customary fees or the 75th percentile.

IL *A 10/89 (+) Illinois increased fees for several dental procedures.

SERVICE	INCREASE
Restorative procedures	10%
Prosthodontic procedures	5%
Extraction procedures	10%

Fees for general anesthesia and intravenous sedation were also increased.

ME *A 10/89 (+) Maine revised reimbursement policies allowing oral surgeons to be reimbursed for the pre-surgical hospital admission of a client separate from, and in addition to, reimbursement for the surgical procedure itself.

MN *A 07/89 (+) Minnesota increased payment for diagnostic and routine preventive services by 7.5 percent, and payment for all other dental services by 0.5 percent.

OH *A 04/89 (+) Ohio increased the following fees in addition to the 2% increase which was effective January 13, 1989, because additional funds became available.

-Most practitioner services (as well as the pharmacy dispensing fee, ambulance services, and

home health services) rendered on a fee-for-service basis increased by 1.5%.
-Practitioner visits increased by 3%.
-Dental sealants increased to $10 per sealant to promote preventive dental care.
-Additional funds were allocated to address the disparity in reimbursement for brainstem evoked response testing, therapeutic radiology and delivery services.

WA *A 03/89 ( ) Washington reinstated payment of molar endodontics at $240 for persons under 21 years of age. Rates for bitewings and fluoride application were reduced to fund this service.

PROCEDURE	OLD RATE	NEW RATE
Bitewings	$10	$ 8
Topical application of fluoride, including prophylaxis	$37	$32
Topical application of fluoride, excluding prophylaxis	$16	$11

11. PODIATRIST SERVICES

A. Amount, Duration and Scope

ME *A 07/89 (+) Maine expanded the range of services which may be rendered by podiatrists and allowed cetain surgical procedures to be performed in podiatrist's offices instead of hospital settings.

OR *A 10/89 (+) Oregon added coverage of podiatry services for clients enrolled in physician's care organizations.

C. Reimbursement

IL *A 09/89 (+) Illinois increased its maximum rates for podiatrist office visits to $16.75 for new patients and $13.65 for established patients.

12. CHIROPRACTOR SERVICES

A. Amount, Duration and Scope

AK *A 02/89 (-) Alaska dropped chiropractic services for one year beginning February 1, 1989. This measure dictated by the state legislature is expected to save $500,000.

FL *A 01/89 (+) Florida Medicaid added chiropractic services.

13. PHYSICAL THERAPY SERVICES

A. Amount, Duration and Scope

AR *A 10/89 (+) Arkansas added the following services to the child
AR *A 08/89 ( ) Arkansas established enrollment requirements for Medicaid providers of occupational, physical, and speech therapies. To qualify, a therapy provider must be a member of that specialty's professional organization or possess equivalent experience. Reimbursement for these therapies is no longer made to providers of rehabilitative services for the developmentally disabled and developmental day treatment clinic services.

CT *A 06/89 ( ) Connecticut revised prior authorization requirements for physical therapy, occupational therapy, and speech and hearing therapy. Without prior authorization, hospitals can be reimbursed for a maximum of 2 physical therapy and 2 speech therapy visits per seven consecutive days, and one occupational therapy visit per 7 consecutive days. In addition, any combination of physical, occupational and speech therapy visits up to 9 visits per calendar year, per patient, per provider may be provided without prior authorization to recipients with certain diagnoses relating to mental retardation, developmental delays, musculoskeletal system disorders, nutrition, and metabolism.

MS *A 07/89 (+) Mississippi added physical, speech, or occupational therapy under EPSDT.

MT *B 05/89 (+) Montana redefined outpatient physical therapy services to include therapy services not provided by a hospital or a home health agency. The outpatient physical therapy services limit has been revised from 70 visits per year to 70 hours per year; an additional 30 hours are allowed with prior authorization.

C. Reimbursement

IL *A 07/89 ( ) Illinois revised LTC therapy services. The following revised rates represent an average of the 11 health service area rates for each therapy.

THERAPY TYPE	REIMBURSEMENT RATE
Speech therapy	$23.98

Occupational therapy (level 1)	41.97
Occupational therapy (level 2)	16.33
Occupational therapy assessment	11.99
Physical therapy (level 1)	42.05
Physical therapy (level 2)	16.33
Physical therapy assessment	11.99
Restorative assessment	11.99

ME *A 11/89 (+) Maine established reimbursement for physical therapy, occupational therapy, and speech and hearing services based upon reasonable cost or the Medicaid maximum. These same services provided in a facility for patients with traumatic brain injury reimbursement is based on actual cost.

MT *A 06/89 (+) Montana limited diagnostic clinic services to speech therapy; audiology; hearing aids; psychologist services; social work services; physical therapy; occupational therapy; and medical and dental evaluation, diagnosis, and treatment services. Reimbursement for diagnostic clinic services is based on negotiated rates not to exceed the cost of thes same services outside of a clinic setting.

14. OCCUPATIONAL THERAPY SERVICES

A. Amount, Duration and Scope

AR *A 08/89 ( ) Arkansas established enrollment requirements for Medicaid providers of occupational, physical, and speech therapies. To qualify, a therapy provider must be a member of that specialty's professional organization or possess equivalent experience. Reimbursement for these therapies is no longer made to providers of rehabilitative services for the developmentally disabled and developmental day treatment clinic services.

CT *A 06/89 ( ) Connecticut revised prior authorization requirements for physical therapy, occupational therapy, and speech and hearing therapy. Without prior authorization, hospitals can be reimbursed for a maximum of 2 physical therapy and 2 speech therapy visits per seven consecutive days, and one occupational therapy visit per 7 consecutive days. In addition, any combination of physical, occupational and speech therapy visits up to 9 visits per calendar year, per patient, per provider may be provided without prior authorization to recipients with certain diagnoses relating to mental retardation, developmental delays, musculoskeletal system disorders, nutrition, and metabolism.

ME *A 04/89 (+) Maine began reimbursing agencies providing occupational therapy services.

MS *A 07/89 (+) Mississippi added physical, speech, or occupational therapy under EPSDT.

C. Reimbursement

IL *A 07/89 ( ) Illinois revised LTC therapy services. The following revised rates represent an average of the 11 health service area rates for each therapy.

THERAPY TYPE	REIMBURSEMENT RATE
Speech therapy	$23.98
Occupational therapy (level 1)	41.97
Occupational therapy (level 2)	16.33
Occupational therapy assessment	11.99
Physical therapy (level 1)	42.05

Physical therapy (level 2)	16.33
Physical therapy assessment	11.99
Restorative assessment	11.99

ME *A 11/89 (+) Maine established reimbursement for physical therapy, occupational therapy, and speech and hearing services based upon reasonable cost or the Medicaid maximum. These same services provided in a facility for patients with traumatic brain injury reimbursement is based on actual cost.

MT *A 07/89 (+) Montana increased all providers' reimbursement by 2%.

MT *B 06/89 (+) Montana limited diagnostic clinic services to speech therapy; audiology; hearing aids; psychologist services; social work services; physical therapy; occupational therapy; and medical and dental evaluation, diagnosis, and treatment services. Reimbursement for diagnostic clinic services is based on negotiated rates not to exceed the cost of thes same services outside of a clinic setting.

15. SPEECH, HEARING AND LANGUAGE THERAPY SERVICES

A. Amount, Duration and Scope

AR *A 08/89 ( ) Arkansas established enrollment requirements for Medicaid providers of occupational, physical, and speech therapies. To qualify, a therapy provider must be a member of that specialty's professional organization or possess equivalent experience. Reimbursement for these therapies is no longer made to providers of rehabilitative services for the developmentally disabled and developmental day treatment clinic services.

CT *A 06/89 ( ) Connecticut revised prior authorization requirements for physical therapy, occupational therapy, and speech and hearing therapy. Without prior authorization, hospitals can be reimbursed for a maximum of 2 physical therapy and 2 speech therapy visits per seven consecutive days, and one occupational therapy visit per 7 consecutive days. In addition, any combination of physical, occupational and speech therapy visits up to 9 visits per calendar year, per patient, per provider may be provided without prior authorization to recipients with certain diagnoses relating to mental retardation, developmental delays, musculoskeletal system disorders, nutrition, and metabolism.

MS *A 07/89 (+) Mississippi added physical, speech, or occupational therapy under EPSDT.

B. Utilization Controls

HI *A 08/89 (+) Hawaii added a prior authorization requirement for cineflouroscopy procedures when done to assist in speech therapy evaluation and as part of restorative treatment. Prior authorization is not required if these procedures are used for medical diagnosis services, i.e., cases of throat mass, ruptured varices, etc.

C. Reimbursement

CT *A 11/89 ( ) Connecticut reimbursed rehabilitation clinics for speech therapy on a per-visit basis. Previously, some clinics were billing half hour units.

IL *A 07/89 ( ) Illinois revised LTC therapy services. The following revised rates represent an average of the 11 health service area rates for each therapy.

THERAPY TYPE	REIMBURSEMENT RATE
Speech therapy	$23.98
Occupational therapy (level 1)	41.97
Occupational therapy (level 2)	16.33
Occupational therapy assessment	11.99
Physical therapy (level 1)	42.05
Physical therapy (level 2)	16.33
Physical therapy assessment	11.99
Restorative assessment	11.99

ME *A 11/89 (+) Maine established reimbursement for physical therapy, occupational therapy, and speech and hearing services based upon reasonable cost or the Medicaid maximum. These same services provided in a facility for patients with traumatic brain injury reimbursement is based on actual cost.

MT *B 06/89 (+) Montana limited diagnostic clinic services to speech therapy; audiology; hearing aids; psychologist services; social work services; physical therapy; occupational therapy; and medical and dental evaluation, diagnosis, and treatment services. Reimbursement for diagnostic clinic services is based on negotiated rates not to exceed the cost of thes same services outside of a clinic setting.

MT *A 05/89 (+) Montana increased reimbursement for speech therapy services from $26.01 to $29.50 per hour for individual treatment and from $15.00 to $17.01 per one and one half-hour group therapy sessions.

17. OTHER NON-PHYSICIAN PRACTITIONER SERVICES

A. Amount, Duration and Scope

ME *A 04/89 ( ) Maine revised its method of calculating the prospective reimbursement rate for ICFs/MR. The calculation is now based on fixed costs, variable costs, and the cost of employee wages, salaries, and fringe benefits. The rules allow ICFs/MR to adjust their interim prospective rate to cover the cost of employee wages, salaries, and benefits.

Maine also revised its limit on certified nurse aide training hours to 150.

MS *A 07/89 (+) Mississippi added reimbursement for licensed registered nurse anesthetists. Payment is at 90% of the payment made to anesthesiologists.

MO *A 11/89 ( ) Missouri added psychiatric nurse services under home health, with a maximum allowable charge per unit of $47.50. These services include patient education and assessment, medication management, and supportive counseling. Psychiatric nursing, considered a skilled nursing service, is covered for recipients meeting home health eligibility criteria and the following conditions:

- o specified diagnoses, including schizophrenic disorders, paranoia, psychosis, and dementia complicated by other disorders;
- o the patient requires active treatment;
- o services are prescribed by a psychiatrist and provided under a care plan reviewed every 60 days by the psychiatrist;
- o services are delivered by a psychiatrically-trained nurse; and
- o the active treatment objectives are measurable by physical criteria.

The services are covered for a 3-week stabilization period, with no more than 2 visits per week. Additional service periods may be approved with documentation of the patient's continued instability. However, these services are subject to the 100 visit per calendar year limit on all home health visits.

MO *A 07/89 (+) Missouri added certified registered nurse anesthetists (CRNAs) as independent providers, allowing CRNAs to bill directly.

NM *A 09/89 (-) New Mexico Medicaid added certified registered nurse anesthetists (CRNAs) as a provider group, allowing for direct reimbursement to them.

SC *A 04/89 ( ) South Carolina began enrolling certified registered nurse anesthetists.

TN *A 07/89 (+) Tennessee began enrollment of certified registered nurse-anesthetists as independent providers.

18. PSYCHOLOGIST SERVICES

A. Amount, Duration and Scope

AR *A 10/89 (+) Arkansas added the following services to the child
AR *A 08/89 (+) Arkansas added coverage of family medical psychotherapy, multiple family group medical psychotherapy, and group medical psychotherapy when provided by a physician with continuing medical diagnostic evaluation, and, when indicated, drug management. An office, hospital, or nursing home is a permissable setting, but a community mental health center is not.

CO *A 07/89 (-) Colorado dropped psychotherapy services provided for several diagnoses, including uncomplicated senile dementia, arteriosclerotic dementia, mild mental retardation, and moderate mental retardation.

HI *A 05/89 (+) Hawaii added continuous eligibility for pregnant women and infants. The women and infants are covered for 60 days postpartum without regard to any increase in income.

KY *A 07/89 (-) Kentucky expanded the definition of the qualifications for a psychiatric nurse employed by a community mental health center to include nurses with any level of education with American Nursing Association certification.

MO *A 11/89 ( ) Missouri added psychiatric nurse services under home health, with a maximum allowable charge per unit of $47.50. These services include patient education and assessment, medication management, and supportive counseling. Psychiatric nursing, considered a skilled nursing service, is covered for recipients meeting home health eligibility criteria and the following conditions:

- o specified diagnoses, including schizophrenic disorders, paranoia, psychosis, and dementia complicated by other disorders;
- o the patient requires active treatment;
- o services are prescribed by a psychiatrist and provided under a care plan reviewed every 60 days by the psychiatrist;
- o services are delivered by a psychiatrically-trained nurse; and
- o the active treatment objectives are measurable by physical criteria.

The services are covered for a 3-week stabilization period, with no more than 2 visits per week. Additional service periods may be approved with documentation of the patient's continued instability. However, these services are subject to the 100 visit per calendar year limit on all home health visits.

OH *A 07/89 (-) Ohio dropped state psychiatric hospital services.

SC *A 10/89 (+) South Carolina increased non-phycisian family therapy and assessment from 3 to 4 units maximum per day.

B. Utilization Controls

MI *A 10/89 ( ) Michigan amended its contract with the Michigan Peer Review Organization (MPRO) to include certification of Medicaid admissions and continued stays in freestanding private psychiatric hospitals and distinct part psychiatric units of general hospitals. Admissions include elective, urgent, emergent and transfers and readmissions. This process will replace the existing review by the Department of Mental Health and by a more limited MPRO PACER review of selected psychiatric admissions. Admissions authorized by community mental health boards are automatically accepted by MPRO, until the first continued stay review.

MS *A 09/89 (+) Mississippi removed the $1.00 copayment for minimal source office visits, emergency room visits, psychiatry sources, and specific opthalmological services.

C. Reimbursement

GA *B 01/90 (+) Georgia proposed revised reimbursement on the 60th percentile of submitted charges for psychology program. In addition, the number of covered hours was increased to 41 hours per recipient under age 21. The projected annual impact is $684,600.

GA *B 01/89 (+) Georgia proposed increasing psychology and vision care services by 4%.

MI *A 07/89 (+) Michigan increased the indigent volume adjuster for freestanding psychiatric hospitals with more than 50% indigent volume.

19. LAB AND X-RAY SERVICES

A. Amount, Duration and Scope

AR *A 07/89 (+) Arkansas added tissue typing as a covered service, payable for both the donor and receiver. Prior authorization is required. Reimbursement is subject to the annual $500 x-ray and laboratory limit.

AR *A 04/89 (+) Arkansas added coverage of MRI. MRI procedures are excluded from the annual $500 lab and X-ray benefit limit.

AR *A 02/89 (-) Arkansas added reimbursement to physicians for electrocardiograms performed in a nursing home. Physicians must own their own equipment and bill for the entire component. Maximum reimbursement is $26.25 for the complete component, which includes the electrocardiogram, routine ECG with at least 12 leads, interpretation, and report.

HI *A 05/89 (+) Hawaii added MRI as a covered service with prior authorization. Payment is limited to a maximum of 3 sequences.

HI *A 05/89 (+) Hawaii added AIDS testing as a covered service. Tests are provided free of charge anonymously, or a test may be obtained through a Medicaid participating private practitioner or laboratory. The Medicaid allowance to providers and laboratories for the initial and confirmatory test can not exceed Medicare's allowance.

KS *A 06/89 (-) Kansas limited some upper gastrointestinal endoscopy procedures to one in a six month period, although more frequent endoscopies may be covered if proven medically necessary.

MD *A 11/89 (+) Maryland changed its hospital administrative day rate to $66.49 for FY 1990. This rate is equal to the average nursing home per diem rate.

OR *A 04/89 (+) Oregon revised reimbursement for diagnostic and therapeutic radiology, nuclear medicine and all other imaging services to a fee schedule system when the services are performed outpatient.

C. Reimbursement

CT *A 01/89 (-) Connecticut revised its fee schedule for independent laboratories to conform with Medicare prevailing rates for laboratory fees.

MO *A 02/89 ( ) Missouri revised its policies on chlamydia culture and chlamydia test packs. A chlamydia test pack procedure was added as a reimbursable coverage in the physician office setting. Chlamydia cultures continue to be reimbursable only for laboratories and outpatient hospital settings. The fee for cultures was increased to $12.00.

NM *A 12/89 (+) New Mexico added reimbursement for non-ionic radiographic contrast media and for gadolinium salts used in MRI, in addition to the payment allowed for the procedure.

20. PRESCRIBED DRUGS

A. Amount, Duration and Scope

AL *A 06/89 (+) Alabama added pentamidine (Nebupet) to its pharmacy program. Pentamidine will only be covered by prior authorization for FDA-approved indications

AL *A 04/89 (+) Alabama redefined basic nursing home services to include:

- o all nursing services to meet total needs of the patient;
- o personal services and supplies for the comfort and cleanliness of the patient;
- o room and board, including special diets & tubal feeding necessary to provide propoer nutrition;
- o serivces and supplies for incontinent patients;
- o bed and bath linens, including linen services such as diapers;
- o safety and treatment equipment such as bed rails and walkers;
- o sterile and non-sterile dressings and medications for prevention and treatment of bed sores; and,
- o over-the-counter (non-legend) floor stock drug products.

AK *A 02/89 (+) Alaska added coverage of prescription drugs.

AR *A 07/89 (+) Arkansas now covers several injections given in conjunction with chemotherapy. They include specified doses of reglan, compazine, benadryl, heparin, hexadral, and solu-medrol. Injections may be provided in the physician's office or outpatient hospital setting.

DESCRIPTION	RATE
Reglan up to 10 mg.	$2.13
Compazine up to 10 mg.	4.39
Benadryl up to 50 mg.	1.52
Heparin single dose up to 100 units	1.33
Hexadol up to 40 mg.	.97
Solu-medrol up to 40 mg.	2.00
Solu-medrol up to 125 mg.	5.31

AR *A 04/89 (+) Arkansas increased prescription drug limits from 4 to 6 presciptions per month per recipient. Pre-

scriptions for contraceptive agents and from EPSDT referrals do not apply towards the 6 prescription limit.

HI *A 08/89 (+) Hawaii added coverage of acyclovir, gancyclovir, interferon alfa, pentamidine, and AZT (retrovir).

IL *A 06/89 ( ) Illinois continued coverage of AZT (retrovir) and added coverage of aerosolized pentamidine and alpha interferon for non-Medicaid patients with HIV-spectrum disease due to an extension of its federal grant for the AIDS Drug Reimbursement Program. All prescriptions must be filled by the state agency's contractor.

KS *A 08/89 (+) Kansas added coverage of pentamidine aerosol (Nebu-Pent) and ganciclovir.

LA *A 09/89 (+) Louisiana eliminated its closed restricted drug formulary and expanded its pharmacy program.

ME *A 02/89 (+) Maine added legend cough and cold preparations and decongestants only for sinusitis, otitis media, emphasema or asthma.

ME *A 02/89 (+) Maine extended coverage under the Maine drugs to the elderly program to allow precription drugs used in the treatment of chronic obstructive pulmonary disease and allowed for a $3.00 copyament for each prescription.

ME *A 02/89 (+) Maine began covering generic prenatal vitamins for pregnancy and up to three months post-partum in quantities of one hundred only. Legend and OTC pre natal vitamins are covered if deemed medically neccessary by a physician.

ME *A 02/89 (-) Maine restricted prescription refills, requiring the following:

- o the prescription must authorize refills; and
- o reimbursement for more than 5 refills of a drug or later than 6 months from the date of the original issue requires a new prescription.

MD *A 07/89 (+) Maryland added coverage of over-the-counter drug products in which ferrous sulfate is the sole active ingredient. Also, ferrous sulfate prescriptions for drops, elixirs, syrups and tablets in specified quantities are covered. The iron supplements were added to treat and prevent lead poisoning in children, pregnant women, and individuals undergoing hemodialysis.

MI *A 03/89 ( ) Michigan is continuing its AZT program for a second year, and is expanding it to include alpha interferon and aerosolized pentamidine in some circumstances. This program is federally funded.

MI *A 03/89 ( ) Michigan is continuing its AZT program for a second year and expanding it to include alpha interferon and aerosotized pentamidine under certain conditions. This program is federally funded.

MI *A 02/89 (-) Michigan began requiring prior authorization for methylphenidate HCL (ritalin) for recipients under age 6 and recipients over age 18.

MS *A 07/89 (+) Mississippi increased its pharmacy dispensing fee to $3.75, and increased the number of prescriptions covered, including refills, from 4 to 5.

NV *A 01/89 (+) Nevada expanded limits on a variety of outpatient services. Physician office visits increased from 2 visits to 5 visits per month with a maximum of 3 visits to one provider. Injections increased from 2 to 5 per month and prescription medication increased from 3 to 5 per month with a maximum 34 day supply.

NJ *A 12/89 (+) New Jersey added coverage of pentamidine for injections or inhalation. Pentamidine for injection requires prior authorization. Pentamidine for inhalation (Nebupent) is limited to 2 vials per claim; additional doses require prior authorization.

NJ *A 06/89 ( ) New Jersey revised the list of MAC multiple source drugs by applying a 150% formula to the lowest list price.

OR *A 01/90 (-) Oregon established a voluntary mail order prescription drug program. Health Care Services, Inc. was selected as the contractor.

OR *A 04/89 (-) Oregon reduced reimbursement for drugs priced on the basis of AWP from 100% of AWP to 89% of AWP. The Oregon MAC (OMAC) is set at 89% of AWP.

OR *A 02/89 (+) Oregon removed from prescription drugs the limitation of six dispensings per month and five refills.

SC *A 07/89 (+) South Carolina increased the prescription drug limit from 3 to 4 per month. Insulin syringes and parenteral therapies are still excluded from the limit.

VA *A 07/89 (-) Virginia no longer covers any transdermal patches.

VA *A 07/89 (-) Virginia limited professional dispensing fees to pharmacists to one per legend drug per month for prescriptions dispensed to non-institutionalized clients.

B. Utilization Controls

AL *A 01/89 (+) Alabama added AZT (retrovir) as a covered drug. Prior authorization is required.

AR *A 03/89 ( ) Arkansas removed prior authorization from all drugs except AZT (Retrovir [100 mg. capsules]) and single source nonsteriodal anti-inflammatory drugs.

CA *B 08/89 (+) California is proposing to add 80 mg. acedaminophen chewable tablets (Tylenol) to the medical drug formulary. Addition of Tylenol to the drug formulary eliminates the need for prior authorization for this drug.

CO *A 10/89 (+) Colorado removed the prior authorization requirement for prescription prenatal vitamins.

KS *A 08/89 (+) Kansas removed its prior authorization requirement for nitroglycerin transdermal patches.

ME *A 11/89 (+) Maine increased the copayment charged by the pharmacy to each Medicaid recipient for each prescription filled or refilled from $0.50 to $0.75

ME *A 02/89 (+) Maine reduced the copay for the Maine Drugs for the Elderly program from $3.00 to $2.00.

ME *A 02/89 ( ) Maine adopted a $0.50 copayment for presciptions and refills. The preventive health program (EPSDT) participants are not required to make copayments.

MD *A 03/89 (-) Maryland now requires physicians to specify the reason a brand name drug rather than a generic has been prescribed.

MD *A 01/89 (-) Maryland established a $ .50 copayment per prescription for Medicaid recipients, and increased the prescription copayment from $.50 to $1.25 for state-only program recipients. Individuals under 21, pregnant women, institutionalized individuals, HMO enrollees, and individuals receiving family planning drugs and devices are exempt from the $.50 federal category copayment.

In addition, Maryland began requiring pharmacy providers to not deny services to any Medicaid eligible due to the individuals inability to make the copayment.

OR *A 01/90 (-) Oregon established a concurrent drug therapy review program for antiulcer therapy. The program also requires prior authorization of continuing antiulcer therapy.

TN *A 10/89 (-) Tennessee added prior authorization as a requirement for most nonsteroidal anti-inflammatory drugs (NSAIDS); certain NSAIDS are exempt. To receive prior approval, a patient must have a diagnosis of chronic arthritis or a related condition and meet one of 3 specified conditions relating to unsuccessful attempts to treat the symptoms with aspirin or generic NSAIDS.

TN *A 10/89 ( ) Tennessee dropped the prior authorization requirement for AZT (retrovir). It added prior authorization for therapy beyond 8 weeks for the following drugs: tagamet, pepcid, axid, and carafete.

VA *A 07/89 (-) Virginia increased copayments on prescriptions to $1.00.

C. Reimbursement

GA *B 01/90 (+) Georgia increased the dispensing fee to $4.41 for non-profit pharmacies. The project annual impact it $510,420.

HI *A 08/89 (+) Hawaii increased the pharmacy dispensing fee from $3.22 to $4.14.

IL *A 09/89 (+) Illinois increased its drug dispensing fee as follows:

- o if the ingredient cost of the drug is less than $35.80, the fee is $3.58; and
- o if the ingredient cost of the drug is equal to or greater than $35.80, the fee is 10% of the calculated ingredient cost, up to a maximum of $15.00 per prescription.

KS *A 10/89 ( ) Kansas began calculating the Estimated Acquisition Cost (EAC) of pharmaceuticals as 90% of the Average Wholesale Price (AWP). Covered drugs are reimbursed at the lesser of the calculated EAC, the Federal Upper Limit (FUL), the State Maximum Allowable Cost (SMAC), or the usual and customary charge.

KY *A 01/89 (-) Kentucky set a pharmacy services upper limit for primary care centers equal to the average amount paid per prescription by the Medicaid program to providers participating in the Outpatient Pharmacy Services program. The average amount will be trended and indexed using Data Resources Inc. inflation factors.

MI *A 01/89 ( ) Michigan modified its hospice program to allow separate billing for AZT. Previously, hospices were required to provide all services to their patients. Now, pharmacies may be reimbursed separately for AZT.

MO *A 07/89 (+) Missouri increased its pharmacy dispensing fee from $3.00 to $3.10.

MO *A 04/89 (+) Missouri rescinded the restrictions placed on reimbursement for anti-ulcer medications dispensed to recipients residing in nursing homes.

MT *A 07/89 (+) Montana increased its pharmacy dispensing fee for outpatient drugs from $4.00 to $4.25 per prescription.

NJ *A 02/89 ( ) New Jersey increased the upper limit for submission of routine prescription drug claims from $99.00 to $199.00.

NM *A 04/89 (-) New Mexico limited the estimated acquisition cost of a drug to the AWP less 10.5% for drugs with an allowed payment of $150 or less. Drugs with an allowed payment over $150 may be paid at actual acquisition cost.

OH *A 04/89 (+) Ohio raised its maximum dispensing fee for prior authorized non-formulary drugs to the lesser of billed charges or $4.00 in recognition of the increased effort involved in obtaining authorization for non-formulary drugs. Under existing policy a non-formulary drug can be authorized:

- -if no formulary drug can treat the patient's medical condition; or
- -physician documents that the formulary generic equivalents have not elicited the desired therapeutic response; or
- -that the generic equivalents have cause an allergic reaction.

OR *A 07/89 (+) Oregon revised drug dispensing fees as follows:

DRUG PROVIDER TYPE	DISPENSING FEE
Filling over 30,000 prescriptions annually.	$3.56
Filling 15,000-30,000 prescriptions annually.	3.69
Filling 1-15,000 prescriptions, or 15,000-30,000 with more than 20% Medicaid prescription volume annually.	3.80
Filling 1-15,000 prescriptions annually with more than 20% Medicaid prescription volume or providers operating with a true or modified dose delivery system as defined by the state.	3.90

SC *A 07/89 (+) South Carolina increased the pharmacy dispensing fee to $4.05 per prescription. South Carolina also increased the patient daily rate for providers participating in the alternative reimbursement method-

ology program for LTC patients to $1.29 per day for government-based providers and $2.50 per patient day for all other programs.

TN *A 10/89 (+) Tennessee implemented a pharmacist dispensing fee of $3.91 per prescription.

TN *A 10/89 (-) Tennessee approved a $6.00 dispensing fee for unit dose medication vendors. For each Medicaid recipient, Medicaid will reimburse a unit dose vendor one $6.00 dispensing fee per month per covered drug. The vendor must dispense the medication in unit dose packaging and dispense at least a 28 day supply. For approved medication dispensed in quantities lasting less than 28 days, Medicaid will reimburse the regular dispensing fee of $3.91. In addition, there is a repackage cost limitation of $0.03 per unit.

21. FAMILY PLANNING SERVICES

A. Amount, Duration and Scope

HI *A 07/89 (+) Hawaii added coverage of family planning services and supplies for all recipients who are sexually active or of child-bearing age regardless of age or category of assistance. These services were previously excluded under the general assistance category.

MI *A 10/89 (+) Michigan added coverage of cervical caps, copper T intra-uterine devices, and contraceptive sponges.

OR *A 01/90 (+) Oregon now reimburses family planning clincs for an annual family planning visit, pregnancy test visit, pap smear, and infection/disease visit.

TX *A 12/89 (+) Texas removed the age restriction on family planning services, making them available for all persons. Previously, these services were not covered for individuals over age 55.

C. Reimbursement

GA *B 10/89 (+) Georgia proposed increasing payment for family planning procedures and expanding the number of covered procedures related to visits, tests, and counseling. The projected annual cost of these services in $106,000.

GA *B 01/89 (+) Georgia proposed increasing from $44.10 to $45.86 the rates for initial and annual visits to family planning clinics. The brief medical or supply visit would increase from $14.30 to $14.87, and confirmation of pregnancy would increase from $10.80 to $11.23. The projected annual cost of these changes is $35,624.

ME *A 01/89 (+) Maine increased maximum fee allowances for some of its family planning agencies.

22. EPSDT SERVICES

A. Amount, Duration and Scope

AL *A 01/90 (+) Alabama increased the number of inpatient hospital days to 14 days per recipient, per calendar year. Additional days may be approved through prior authorization for EPSDT participants and for women with medically necessary days following a delivery.

AL *A 09/89 (+) Alabama added coverage of comprehensive multidisciplinary developmental screening assessments through EPSDT. The program is limited to infants, and the screening is limited to 2 per recipient per lifetime.

AL *A 07/89 (+) Alabama added medically necessary orthodontic treatment for EPSDT recipients. The services must be delivered by Alabama Crippled Children Service orthodontic clinics. These services require prior authorization.

AL *A 02/89 (+) Alabama added dental sealants under EPSDT, limited to one application per tooth in a recipient's lifetime. Teeth must be free of proximal caries and restorations. Sealants may be applied to permanent first molars on children age 5-8, and to permanent second molars on children age 11-13.

AL *A 01/89 (+) Alabama added liver transplant as covered only for children who qualify under the EPSDT program. Prior authorization is required. Payment will be made at 75% of charges up to a maximum payment of $125,000.

AR *A 01/90 (+) Arkansas limited personal care services to 42 hours per month, per recipient. Additional hours may be approved for children under the EPSDT program.

AR *A 01/90 (-) Arkansas limited home health care visits by a home health nurse, a home health nurse aide, or a combination of the 2 to 25 visits per state, per fiscal year. Additional visits may be approved for children under the EPSDT program.

AR *A 01/90 (-) Arkansas limited inpatient hospital services to 25 days per state fiscal year. In life-threatening situations for children, additional days may be approved under the EPSDT program.

AR *A 10/89 (+) Arkansas added the following services to the child
IL *A 09/89 (+) Illinois added follow-up visits under the Healthy Kids Program (EPSDT) at a maximum rate of $30.00 Follow-up visits are limited to one per child per health screening age period.

IL *A 04/89 (+) Illinois increased the number of EPSDT periodic health screenings to 18 and expanded its list of covered diagnostic procedures.

KS *A 01/90 ( ) Kansas dropped a requirement that children under age three have a KAN Be Healthy (EPSDT) medical screen before receiving dental services.

KY *A 03/89 (+) Kentucky added a second EPSDT screening, with documentation of medical necessity, for each time span of its periodicity schedule.

ME *A 08/89 ( ) Maine began reimbursing ambulatory care clinics for Preventive Health Program (EPSDT) services.

MN *A 07/89 (+) Minnesota appropriated funds for the development of a mental health screening tool.

MS *A 07/89 (+) Mississippi added physical, speech, or occupational therapy under EPSDT.

OK *A 02/89 (-) Oklahoma limited inpatient hospital services for EPSDT recipients to 60 days per fiscal year. Exceptions may be granted for catastrophic illnesses.

SC *A 07/89 (+) South Carolina revised its EPSDT screening schedule according to the American Academy of Pediatrics' recommendations to include 20 screenings from birth to age 21, 9 of which are allowed from birth to age 2.

C. Reimbursement

CT *A 03/89 (+) Connecticut revised reimbursement rates for EPSDT services.

GA *B 01/89 (+) Georgia proposed increasing the rate for a complete EPSDT well-child screen from $33.00 to $34.32. This change has a projected annual cost of $137,408.

HI *A 05/89 (+) Hawaii extended coverage to QMBs up to 100% of poverty. For non-Medicaid services, coinsurance payments will be made at the Medicare payment level.

IL *A 09/89 (+) Illinois increased by 5% the maximum rate for diagnostic services under its Healthy Kids Program (EPSDT).

MN *A 07/89 (+) Minnesota increased the public health clinic and community health clinic services payment rate by 20%.

23. OTHER DIAGNOSTIC, SCREENING AND PREVENTIVE SERVICES

A. Amount, Duration and Scope

AL *A 01/89 (+) Alabama added coverage of MRI scans of the skull and spine.

CT *A 01/89 (+) Connecticut added neuropsychological evaluations, which include assessment of perceptual/motor functions, language functions, attention, memory, learning, intellectual processes, emotion, behaviour, and personality.

HI *A 03/89 (+) Hawaii added immunizations for Hepatitis B for the following recipients:

- o infants born to positive reactor mothers and other eligible household members in close contact with positive reactor mothers;
- o eligible sexual partners of positive reactor recipients; and
- o refugees from southeast Asia who have been tested and determined to be negative.

KS *A 06/89 (+) Kansas added coverage of influenza virus vaccines and pneumococcal vaccines when administered by local health departments and home health agencies. The vaccine cost and an administrative fee is paid. Flu vaccine is not covered for recipients of adult care homes.

KS *A 04/89 (+) Kansas began covering Prenatal Risk Reduction (PRR) Nutrition Visits, Prenatal Health Promotion, and Risk Reduction Services for women who meet risk criteria when services are provided by an approved local health department. Recipients must receive other prenatal risk reduction services in conjunction with the PRR Nutrition Visits.

MN *A 07/89 (+) Minnesota appropriated funds for the development of a mental health screening tool.

MO *A 06/89 (+) Missouri revised coverage of ultrasound. Reimbursement is available for up to 3 ultrasound procedures during any one calendar year, when reason-

able and necessary. Additional ultrasound may be provided and reimbursed if a completed medical necessity form is attached to the patient claim.

NV *A 01/89 (+) Nevada expanded limits on a variety of outpatient services. Physician office visits increased from 2 visits to 5 visits per month with a maximum of 3 visits to one provider. Injections increased from 2 to 5 per month and prescription medication increased from 3 to 5 per month with a maximum 34 day supply.

TN *A 07/89 (+) Tennessee added coverage of a second measles, mumps and rubella (MMR) vaccine for EPSDT recipients.

TX *A 12/89 (+) Texas added coverage of chromosome analysis with most procedures limited to once per lifetime.

TX *A 09/89 (+) Texas added medically necessary pneumonia and influenza immunizations for the following high-risk recipients: the elderly (over age 60), nursing home residents, children under age 2, the chronically ill or severely disabled, and people with weakened immune systems. Pneumococcal immunizations are payable once per lifetime; influenza immunizations are payable yearly.

VA *A 07/89 (-) Virginia added coverage of blood and urine self-monitoring test strips for children with diabetes.

B. Utilization Controls

HI *A 04/89 (+) Hawaii added a prior authorization requirement for pneumograms and sleep apnea studies.

TN *A 07/89 (-) Tennessee limited reimbursement for mammograms to one per recipient per fiscal year. For recipients under age 35, prior approval also is required.

C. Reimbursement

MO *A 01/89 (+) Missouri increased the reimbursement for Hemophilus Influenza B vaccine from $7.80 to $18.50 per dose.

MT *B 06/89 (+) Montana limited diagnostic clinic services to speech therapy; audiology; hearing aids; psychologist services; social work services; physical therapy; occupational therapy; and medical and dental evaluation, diagnosis, and treatment services.

Reimbursement for diagnostic clinic services is based on negotiated rates not to exceed the cost of thes same services outside of a clinic setting.

24. REHABILITATIVE SERVICES

A. Amount, Duration and Scope

AL *A 10/89 (+) Alabama expanded services provided through community mental health centers to include substance abuse services.

AR *A 12/89 (-) Arkansas dropped rehabilitative services for the developmentally disabled. These services were dropped because HCFA disapproved the state plan amendment under which Arkansas began coverage of the services in February, 1989.

AR *A 02/89 (+) Arkansas added coverage of rehabilitative services for the developmentally disabled with a written request from a physician.

CT *A 07/89 (+) Connecticut added neuropsychological evaluations as a covered mental health and rehabilitation clinic service. Neuropsychological evaluations are limited to one in any 12 month period per provider for the same recipient, and are reimbursed at $450.00.

IL *A 01/89 (+) Illinois increased some restorative therapy services to one every 30 days rather than one every 90 days.

KS *A 10/89 (+) Kansas began reimbursing qualified mental retardation professionals (QMRPs) for HCBS pre-admission screening services. Previously, only health departments, home health agencies, or registered nurses could provide this service.

ME *A 07/89 (-) Maine limited reimbursement for day habilitation services to retarded persons from ICFs-MR only, and raised the reimbursement ceiling to $16,500 per client per year. Maine also dropped transportation to and from the day habilitation site.

MA *A 10/89 (+) Massachusetts added coverage of the following substance abuse treatment services:

- o free-standing inpatient drug detoxification;
- o methadone maintenance;
- o outpatient counseling, including individual and family therapies; and
- o acupuncture detoxification.

NV *A 03/89 (+) Nevada now requires that adult day health care provide treatment/therapy for clients with memory problems.

NV *A 03/89 ( ) Nevada eliminated the psychiatric social worker as a required member of the multi-disciplinary team within an adult day health care facility.

WI *A 05/89 (+) Wisconsin implemented a new psychiatric and alcohol and other drug abuse (AODA) independent review system (PAIRS), intended to more rigorously review the need for inpatient psychiatric care and AODA care for WMAP recipients. PAIRS will apply to limited AODA and psychiatric diagnosis for covered psychiatric and AODA hospital inpatient admissions and stays.

WI *A 03/89 (+) Wisconsin added alcohol and other drug abuse (AODA) day treatment as a covered service. AODA day treatment is limited to categorically needy recipients diagnosed with an alcohol and/or drug dependency or abuse.

B. Utilization Controls

AR *A 12/89 (+) Arkansas Medicaid now requires pre-certification for alcohol, chemical dependency, and psychiatric treatment admissions to a rehabilitative hospital. Pre-certification is only required if Medicaid is the primary payor.

NV *A 03/89 (-) Nevada added prior authorization for adult day health care.

NV *A 03/89 ( ) Nevada began allowing completion of the required physical exam within 30 days after admission to an adult day care facility if the applicant's physician has an examination and history.

C. Reimbursement

CA *A 10/89 (+) California increased LTC rates as follows.

SERVICE	% INCREASE
ICF	14.0
ICF-DD	9.4
ICF-Developmentally Disabled Habilitative	14.9
ICF-DD Nursing	18.8
SNF	16.3
SNF-Subacute Care Reimbursement	5.8

	Short Doyle Medi-Cal	8.1
	Leave of Absence	8.6
	Bed Hold for Acute Hospitalization	8.6
	Adult Day Health Care	16.2

GA *B 01/90 (+) Georgia proposed the following rate changes to the community care services waiver program:

Adult Day Rehabilitation-$40 full day; $24 half day
Homemaker Aide Services - $8 per 1/2 hour;
Alternative Living Services - family and group model personal care home rates - $18.38 per day;
Respite Services - $9 per hour;
Home Delivered Services - 14 percent increase, up to a maximum of 6.13 per visit; and,
Personal Care Aide - $8.27 per 1/2 hour ($700 maximum per month).

The proposed changes are expected to increase aggregate expenditures by $2,827,748.

KY *A 07/89 (+) Kentucky increased the upper limits for the following outpatient services:

o psychosocial rehabilitation services (partial hospitalization)	$ 8.27
o outpatient (clinical)	14.15
o personal care (off-site)	3.09
o inpatient (off-site)	20.28

ME *A 11/89 (+) Maine established reimbursement for physical therapy, occupational therapy, and speech and hearing services based upon reasonable cost or the Medicaid maximum. These same services provided in a facility for patients with traumatic brain injury reimbursement is based on actual cost.

ME *A 04/89 (+) Maine increased the maximum allowance for case management to $30.00 per half hour and for adult day health to $6.00 per half hour.

MD *A 07/89 (+) Maryland increased its maximum per diem for medical day care to $38.97. The rate of increase was based on a percentage of wage increases as determined by CPI for the Baltimore area.

WA *A 11/89 ( ) Washington changed its payment method for hospital-based intensive care programs for clemical-using pregnant women from a DRG system to a percentage of charges.

25. TRANSPORTATION SERVICES

A. Amount, Duration and Scope

AR *A 11/89 (-) Arkansas no longer reimburses for ambulance service waiting time.

CT *A 07/89 (+) Connecticut added coverage of air transportation if it is less expensive than alternative means of transportation. In addition, coverage of a critical care helicopter is covered if its utilization is medically or financially justifiable over ground transportation based on state-specified criteria. Payments for transportation are not made to relatives or foster parents of a hospital inpatient, unless the relative requires training to provide unpaid health care in the home to the recipient.

GA *B 01/90 (+) Georgia proposed to discontinue payment for transportation costs through community mental health center services. The projected annual savings for this program change is $402,700.

ME *A 07/89 (-) Maine limited reimbursement for day habilitation services to retarded persons from ICFs-MR only, and raised the reimbursement ceiling to $16,500 per client per year. Maine also dropped transportation to and from the day habilitation site.

MD *A 07/89 ( ) Maryland dropped payment of unloaded miles to transportation providers. Also, it added coverage of transportation to or from a Veterans' Administration Hospital for a medical service not related to military service.

MD *A 07/89 (+) Maryland added transportation to any medically necessary covered service.

MI *A 05/89 (+) Michigan began automated billing services for helicopter air ambulance services when:

1. time and distance in a ground ambulance would be a hazard to the life of the patient; and
2. necessary care and services are not available at the local hospital, and transport is required for medical or surgical treatment, not for diagnosis only.

MN *A 07/89 (+) Minnesota added intermediate ambulance services.

WA *A 07/89 (+) Washington contracted for transportation brokers to assure non-ambulance transportation to and from covered services.

B. Utilization Controls

CT *A 07/89 (-) Connecticut added prior authorization as a requirement for all transportation sources except emergency ambulances and non-emergency ambulances with designated medical conditions.

CT *A 04/89 (+) Connecticut added a prior authorization requirement for taxi and livery trips from nursing homes.

IL *A 07/89 ( ) Illinois dropped prior approval requirements for transportation services for LTC residents.

KS *A 09/89 (+) Kansas dropped the prior authorization requirement for non-emergency ambulatory transportation if the recipient is Medicare/Medicaid eligible, and Medicare and Medicare allows the service.

MD *A 07/89 (-) Maryland added prior authorization for:

- o individual transportation trips costing over $125;
- o charges over $25 for an attendant, except when the recipient is a child under 18 and the attendant is the parent or guardian;
- o trips to or from parental training; and,
- o ambulance trips over twenty miles.

C. Reimbursement

AR *A 01/90 (+) Arkansas added prior authorization as a requirement when performing cholecystectomy; hip, knee, or ankle replacement; transurethral resection; or prostate procedures.

AR *A 04/89 (+) Arkansas increased the reimbursement rate for personal care transportation from $0.21 to $0.23 per mile.

GA *B 07/89 (-) Georgia proposed changing reimbursement to minibus and wheelchair van providers by implementing a base rate of $6.50 per recipient, which will include the first 10 miles. The mileage rate for the minibus would be increased from $.50 to $.70 per mile per trip, regardless of the number of recipients transported.

IL *A 09/89 (+) Illinois increased ambulance provider rates by an average of 6%, with the maximum increase limited to 80% of the 50th percentile of the Medicare prevailing charge.

MA *A 09/89 (-) Massachusetts entered into selective contracting agreements for medical transportation in certain areas of the state.

26. EYEGLASSES

A. Amount, Duration and Scope

NJ *A 03/89 (-) New Jersey vision care services only allows for coverage of new lenses if a vision change is at least 0.50 diopter in spherical or cylindrical power, or a change of 5 degrees or more in cylinder axis.

OR *A 12/89 (-) Oregon revised coverage of usual services as follows:

- o adults covered for 1 pair of glasses every 24 months, except 1 additional pair of glasses is covered within 120 days following cataract surgery;
- o children will be covered for services and materials with medically necessary documentation;
- o vision therapy sessions for children have been limited, but do not require prior authorization; and
- o low visual aids and some miscellaneous items will no longer be covered.

C. Reimbursement

HI *A 06/89 (+) Hawaii increased reimbursement for selected vision supplies.

Nose pads with arms	$ 8.00/pair
Eyeglass cases	1.50
Eyeglass frames	15.00

27. HEARING AIDS

A. Amount, Duration and Scope

OH *A 05/89 (+) Ohio added a maximum allowance of 2 minor hearing aid repairs per year up to $40 each, and one major repair per year between $40 and $100. The hearing aid repair reimbursement is for parts, labor, and postage/delivery.

WI *A 07/89 (+) Wisconsin now allows hearing aid dealers to provide hearing evaluations to fit and dispense hearing aids to recipients age 22 or older who are developmentally unimpaired. Although the hearing aid dealers may provide the services, they are not reimbursed for them unless they are also medical assistance-certified audiologists. In addition, Wisconsin added coverage of certain fixed prosthodonic procedures in April, 1989.

B. Utilization Controls

IL *A 01/90 (+) Illinois dropped the prior authorization requirement for monaural hearing aids.

MO *A 02/89 (-) Missouri initiated a prior authorization requirement for hearing aids and related services, except for audiological testing, post-fitting evaluations and adjustments, and repairs to hearing aids no longer under warranty. The limitation of 3 post-fitting adjustments and/or hearing aid repairs for a 12-month period is retained.

MO *A 02/89 (-) Missouri initiated a requirement that nursing home recipients' requests for audiological testing and hearing aids are acceptable when prior authorized, but a mass screening of nursing home residents is not.

C. Reimbursement

MO *A 01/90 (+) Missouri increased the maximum reimbursement for hearing aid dispensing to $13.50.

28. DENTURES

A. Amount, Duration and Scope

AL *A 07/89 (+) Alabama added medically necessary orthodontic treatment for EPSDT recipients. The services must be delivered by Alabama Crippled Children Service orthodontic clinics. These services require prior authorization.

AL *A 02/89 (+) Alabama added dental sealants under EPSDT, limited to one application per tooth in a recipient's lifetime. Teeth must be free of proximal caries and restorations. Sealants may be applied to permanent first molars on children age 5-8, and to permanent second molars on children age 11-13.

MA *A 03/89 (+) Massachusetts added the following dental services: adult sealants, topical fluoride treatments, immediate dentures, Maryland bridges, and treatment of the handicapped code for developmentally delayed recipients in the office. In addition, other services were expanded, such as prophylaxis, radiographs, space maintainers, and root canal therapy.

OK *A 07/89 (+) Oklahoma added coverage of basic need restorative dental care, described under EPSDT, and adaptive equipment (equipment, appliances, and prosthetic devices) beyond the scope of Medicaid for adults and children in private ICFs/MR. Prior authorization is required.

C. Reimbursement

CA *A 10/89 (+) California increased dental, orthodontic, and maxillofacial services by 5%.

KS *A 07/89 (+) Kansas increased the allowable dental treatment plan reimbursement to $2,000. Treatment plans exceeding $2,000 require prior authorization.

KY *A 01/89 (-) Kentucky established a dental services upper payment limit for primary care centers equal to the average amount paid per utilizer by the Medicaid program to all participating dental providers. The average amount will be trended and indexed using Data Resources Inc. inflation factors.

29. PROSTHETIC DEVICES

A. Amount, Duration and Scope

AZ *A 03/89 (+) Arizona added coverage of enteral nutrition.

VA *A 07/89 (+) Virginia added artificial arms, legs, and supportive devices used to attach artificial arms and legs when prescribed by a physician, preauthorized, and furnished by a participating provider.

C. Reimbursement

GA *A 01/89 (+) Georgia increased orthotic and prosthetic service rates by 4%. The projected annual cost of these increases is $158,792.

OR *A 07/89 ( ) Oregon set End Stage Renal Dialysis reimbursement at 80% of the Medicare maximum allowable charge.

OR *A 04/89 (-) Oregon reduced reimbursement to free-standing dialysis facilities to 54% of cost, as part of an effort to balance the medical budget.

30. DURABLE MEDICAL EQUIPMENT AND SUPPLIES

A. Amount, Duration and Scope

KY *A 07/89 (+) Kentucky established reimbursement for out-of-state home health agencies at the lower of the Medicare rate, Medicaid rate, or the agency's actual usual and customary charge. Reimbursement for disposable medical supplies are at 80% of actual usual and customary charges.

KY *A 05/89 (+) Kentucky added DME. Prior authorization is required for DME items over $150 and for DME recipients who have other third party coverage (excluding Medicare). Disposable medical supplies are limited to those currently reimbursable by Medicare. Also, as of July, 1989, DME suppliers can no longer bill through the home health system.

MI *A 11/89 (+) Michigan increased the maximum number of diapers and incontinence liners to 300 per month and disposable underpads to 180 per month under the Children's Special Health Care Services Program. Additional quantities can be obtained with prior authorization.

B. Utilization Controls

AR *A 11/89 (+) Arkansas added coverage of ambulatory infusion devices, with prior authorization, for patients receiving chemotherapy, pain management, or antibiotic treatment in the home. Related drugs and supplies are billed separately.

HI *A 08/89 (-) Hawaii increased the dollar threshold to $100.00 for medical supplies, prostheses, and orthotics that may be dispensed without prior authorization. Cumulative rentals and supplies or equipment costing more than $100 still require prior authorization.

ID *A 10/89 (+) Idaho excluded equipment costing less than $50 from prior authorization.

IL *A 02/89 ( ) Illinois revised prior authorization requirements for medical supplies. Patients with medical de-

terminations indicating a 6 month or more need for medical supplies will be granted a one year approval, except for supplies with specific restrictions.

KS *A 04/89 ( ) Kansas dropped the prior authorization requirement for home apnea monitor rental.

MI *A 08/89 (+) Michigan added customized DME for LTC clients with a written statement by the attending physcian. Prior authorization is required for a patient's full-time use of such customized equipment. Previously, DME was limited to an allowable offset of the patient-pay amount for LTC patients.

MT *A 06/89 ( ) Montana revised the copayment for DME, prosthetic devices, and medical supplies to a universal $0.50 per item, decreasing the $3.00 per-item copayment previously required on prior authorized items.

MT *A 01/89 (+) Montana removed the prior authorization requirement for oxygen supplies.

SC *A 07/89 (+) South Carolina dropped prior authorization for the following diabetic supplies: glucometers, autolets, chemstrips, lancets, and control. Chemstrips and lancets are limited to 100 each per month, control is limited to one bottle every 3 months, and the purchase of glucometers and autolets will be paid once per recipient. Claims are subject to review.

TN *A 08/89 (+) Tennessee now allows selected supplies, previously available only through home health agencies, to be reimburseable through medical vendors for recipients receiving only supplies, not services. For items necessitating training, suppliers must submit documentation verifying recipient training. The statement must be signed by the recipients or a family member, the physician, or the previous home health agency. This statement is also required from home health agencies for recipients receiving supplies only. Supplies furnished by a home health agency for "supplies only" receipients must be prior approved.

TN *A 07/89 (-) Tennessee added an additional documentation requirement for prior approval requests for power wheelchairs and specialized seating systems. Documentation must include medical diagnosis and physical limitations to support the need for such items.

Documentation also must be shown that a physical therapist or occupational therapist had active input into the fitting of the recipient's equipment.

C. Reimbursement

GA *B 01/89 (+) Georgia proposed increasing DME service rates by 4%. The projected cost of this change is $179,248.

TN *A 08/89 (+) Tennessee reduced the maximum monthly rate for oxygen concentrators and standard stationary oxygen systems, both liquid and gaseous, to $268.83. Seat lift chairs also are no longer covered.

TN *A 08/89 (-) Tennessee Medicaid decreased reimbursement for TENS units (electro-nerve stimulators) to $400.00 for units with a 2 year warranty. Prior approval is required. Prior approval requests for TENS units must show documentation of a decrease in pain medication during the 30-day trial period.

TN *A 07/89 (-) Tennessee limited the reimbursement amount for total cost of repairs to DME to 75% of the allowable replacement cost of the equipment. This limit is cumulative over the life expectancy of the equipment.


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31. SNF AND ICF SERVICES

A. Amount, Duration and Scope

AZ *A 01/89 (+) Arizona implemented the Arizona Long-Term Care Program (ALTCS) for the elderly and physically disabled. ALTCS uses a prepaid capitated approach to providing LTC services via a managed care system. Services include: SNF, ICF, ICF/MR, HCBS, acute medical services and supplies, and case management.

AR *A 02/89 (-) Arkansas added reimbursement to physicians for electrocardiograms performed in a nursing home. Physicians must own their own equipment and bill for the entire component. Maximum reimbursement is $26.25 for the complete component, which includes the electrocardiogram, routine ECG with at least 12 leads, interpretation, and report.

CA *A 03/89 (-) California removed the 6.2 minimum daily average licensed nursing hours requirement for ventilator-dependent patients in subacute care units. In addition, nurse staffing requirements were reduced from one RN and one licensed vocational nurse (LVN) per shift to one RN per shift.

LA *A 05/89 (+) Louisiana added SNF care for technology-dependent children. Reimbursement for this service is based on costs not to exceed a specified per diem rate.

ME *A 09/89 (-) Maine eliminated the two-third SNF or ICF per diem reimbursement for a resident no longer in need of the care provided that facility. Maine will reimburse the regular per diem for 15 days (and one 15-day extension) after a resident reclassification. If a SNF resident is reclassified as ICF level of care, the SNF will be reimbursed at its ICF rate or at the statewide average rate.

MA *A 06/89 (-) Massachusetts established a demonstration project that uses provider teams with both physician and nurse practitioner/physician assistants (NP/PA's) to treat patients in nursing homes.

SC *A 09/89 ( ) South Carolina revised the nursing home bed policy to follow Medicare's policy of canvassing a 50-mile radius for a bed, rather than the whole state.

SC *A 04/89 (-) South Carolina expanded subacute care to include ventilator-dependent individuals determined by a hospital utilization review committee or the PRO to require nursing facility level of care. Hospitals, SNFs, and ICFs on contract with the Medicaid agency are paid $150 per day for this subacute care.

VA *A 07/89 (-) Virginia reinstated reimbursement to nursing homes located in planning districts with occupancy rates of 96% or more, to a maximum of 12 days per hospital admission for nursing home patients requiring temporary hospitalization.

WV *A 04/89 (-) West Virginia limited hospital administratively necessary days to 30.

B. Utilization Controls

AL *A 04/89 (-) Alabama added a prior authorization requirement for skilled nursing facilities services for individuals 21 years or older. Prior authorization will be based on medical necessity.

AL *A 04/89 (-) Alabama added prior authorization, based on medical necessity, for intermediate care facility services for individuals age 65 or older in mental disease institutions.

AL *A 01/89 (-) Alabama Medicaid will pay dually certified facilities the coinsurance amounts for the first eight days of skilled level care. No payment will be made by Medicaid for the 9th day through the 150th day for Medicare eligible patients. Medicare covers up to 150 days of skilled nursing care services in a calendar year.

CT *A 04/89 (+) Connecticut added a prior authorization requirement for taxi and livery trips from nursing homes.

CT *A 02/89 ( ) Connecticut established criteria and procedures for facilities "at risk" of being classified as institutions for mental disease (IMD). Criteria for identifying institutions at risk include: facilities with more than 40% of their population diagnosed as psychiatric patients; those with more than 40% of their population transferred from a state

mental institution; and those advertising themselves as facilities for treatment of mental disease. At risk facilities are denied approval for new psychiatric admissions until the psychiatric population is below 45% of the facility's Medicaid population, or 50% of the facility's total population. At risk facilities must submit acceptable plans of correction as a condition of continued Medicaid participation. Such facilities are held responsible for any federal financial penalties imposed due to a determination that they are IMDs.

KS *A 01/89 (+) Kansas now permits physician extenders to certify adult care home admissions. Previously, they were allowed to recertify adult care home stays.

MS *A 07/89 (+) Mississippi increased the number of home/therapeutic leave days for nursing home recipients to 36 days per fiscal year. Written physician authorization is required before payment is made for more than 18 days.

NJ *A 02/89 (-) New Jersey added preadmission screening of all Medicaid recipients and individuals who may become Medicaid eligible within six months following admissions to Medicaid participating SNF/ICF facilities. The program began in one county in February. Additional counties were added in October. The program will expand to the remaining counties in February 1990.

OH *A 07/89 (+) Ohio extended its moratorium on ICF and SNF beds to permit approval of additional beds for special populations when an unmet need can be established.

C. Reimbursement

AL *A 07/89 (+) Alabama increased reimbursement for nursing services in ICF/SNF-MDs to allowable cost, not subject to the 60th percentile upper limit.

AL *A 06/89 (+) Alabama lifted its moratorium on new nursing home beds, which had been established on April 1, 1983.

AL *A 04/89 (-) Alabama limited nursing home depreciation recapture to the amount reimbursed to the seller through the per diem rates.

CA *A 10/89 (+) California increased LTC rates as follows.

SERVICE	% INCREASE
ICF	14.0
ICF-DD	9.4
ICF-Developmentally Disabled Habilitative	14.9
ICF-DD Nursing	18.8
SNF	16.3
SNF-Subacute Care Reimbursement	5.8
Short Doyle Medi-Cal	8.1
Leave of Absence	8.6
Bed Hold for Acute Hospitalization	8.6
Adult Day Health Care	16.2

CA *B 00/89 (+) California revised reimburement rates for subacute services. The new rates include all services, equipment, and supplies necessary for the administration of treatment.

TYPE OF LICENSURE	TYPE OF PATIENT	RATE OF REIMBURSEMENT 08/88	08/89
Hospital-based	Ventilator-dep.	$315.49	$332.35
Freestanding	Ventilator-dep.	205.01	220.38
Hospital-based	Not Vent.-dep.	297.99	313.94
Freestanding	Non Vent.-dep.	187.53	201.99

Previously, many ancillary services were not included in the subacute per diem rate.

GA *B 11/89 (+) Georgia proposed increases in reimbursement for non-administrative nursing home staff. The increase in reimbursement will include a maximum per diem increase of $1.87. The increase determined for each facility will be an add-on to its established total per diem rate.

ID *A 03/89 (+) Idaho now allows certain nursing homes to receive higher property reimbursement to cover new additions to existing buildings.

IL *A 07/89 (-) Illinois implemented its Exceptional Care Program to provide services for residents with exceptional care needs in long term care nursing facilities. A facility specific rate rather than a client specified rate is negotiated for a select number of beds to be utilized for the services provided. Exceptional care is defined as the level of medical care required by persons who are medically stable and ready for discharge from a hospital but who require

a multi-disciplinary level of care for physicians, nurse and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be medically necessary (includes persons with AIDS, head injured persons, and ventilator-dependent persons). For a person to be approved for exceptional care placement, the cost of the person's care must be at least 50% more than the nursing facility's per diem rate (capital, support, and nursing components). Utilization of services is subject to a 90-day review.

Providers must meet a number of criteria including:

1. acceptance of 75% of all persons approved if facility is at less than 95% occupancy;
2. demonstration of ability to provide specialized nursing and therapeutic care with shift staffing specifications; and
3. documentation of specialized training and inservicing of all staff.

IL *A 03/89 (+) Illinois initiated a pilot program to reimburse hospitals for extended stays when appropriate skilled nursing facility beds are not available. To be eligible a hospital must document its attempt to place the patient in at least five appropriate facilities. Reimbursement is limited to services provided after the minimum number of contacts have been made and reimbursement is not made for services which were billed as acute care and denied as not being medically necessary.

Two levels of care may be reimbursed:

1. If the patient's needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed, the rate is the average skilled statewide rate for skilled nursing care ($48.86).
2. If the level of care is not routinely performed within a skilled setting and the patient cannot be placed in a SNF because the level of care is unavailable, the rate is the average statewide negotiated rate for exceptional care ($123.00).

IA *A 01/89 ( ) Iowa began determining ICF maximum allowable cost at a level where 74% of participating facilities receive 100% of allowable costs.

KS *A 01/89 ( ) Kansas revised hospital swingbed rates to:
SNF - $44.93
ICF - $36.84

KY *A 07/89 ( ) Kentucky revised ICF and SNF reimbursement as follows:

- o facilities eligible for a closed head injury program will be paid usual and customary charges up to a maximum of $360 per patient day;
- o maximums for ICF/SNF owners and administrators were updated for inflation*;
- o SNFs and ICFs allowed $1.38 per diem for nurse aide training and $1.20 per diem for implementation of universal precautions;
- o SNFs and ICFs caring for patients with highly infectious or communicable diseases with limited treatment potential are reimbursed usual and customary charges up to a maximum of $95 for SNFs and $75 for ICFs per diem on qualifying patients;
- o maximums for routine costs were changed to $43.78 for ICFs, $62.32 for SNFs, $77.90 for hospital-based SNFs, and $74.78 for SNFs/MR; and
- o the following limitations were placed on ICF and SNFs cost centers:

COST CENTER	ICF	SNF FREE-STANDING	SNF HOSPITAL-BASED
Nursing	$16.84	$31.73	$39.66
Dietary	7.29	7.15	8.94
Capital	4.07	5.57	6.96
All Other	17.40	23.69	29.61

KY *A 01/89 (-) Kentucky reduced the upper limit for hospital-based SNFs from 135% to 125% of the upper limit on free-standing facilities. As of October 1, 1989 it will be reduced to 115%, and then on July 1, 1990 to 105%.
In July 1989, the October 1989 and July 1990 reductions were cancelled. In addition, the state determined that the maximum payment includes the allowance for nurse aide training and universal precautions.

ME *A 04/89 (+) Maine amended the principles of prospective reimbursement for ICF, SNF, and ICF-MR to allow employee wages, salaries, and benefits to be reimbursed at reasonable cost. The rules establish pay in lieu of benefits as an allowable cost, transfer certain fixed costs to the variable cost components and allow reimbursement for up to 150 hours of cert ified nurses aide training coursework.

MD *A 07/89 (+) Maryland revised nursing home facility rates for fiscal year 1990 as follows:

- o nursing service rates for the 5 regions were set based on the January 1989 wage survey and included a nursing supplies allowance of $1.13 per day. Nursing fringe benefit factors were set for the 5 regions;
- o Administrative and routine cost ceilings, which increased for all regions, were set at 115 percent of the median day cost;
- o ceilings for other patient care costs were set at 120 percent of the median day cost; and
- o nursing home facility appraisals were indexed for fiscal year 1990 rate setting.

MA *A 01/90 (-) Massachusetts began utilizing a prospective, patient care mix system to determine reimbursement for 190 of the state's nursing homes.

MA *A 12/89 (+) Massachusetts established program regulations and an enhanced reimbursement rate for skilled nursing home units designated for AIDS patients.

MA *A 07/89 (-) Massachusetts entered into selective contracting agreements for specialized nursing home services in the least restrictive environment to serve Alzheimers disease patients.

MN *A 07/89 (+) Minnesota increased nursing home rates an average of 8.97% statewide for an average rate increase of $5.49 per resident per day.

MT *A 07/89 (+) Montana increased NF reimbursement by 3% and added $2.00 per patient per day to cover NF costs associated with compliance with OBRA '87 requirements.

NV *A 01/89 ( ) Nevada revised the operating rates for nursing facilities. The new rates are inclusive of all areas of cost except property which will be paid separately.

ICL-I	- $33.14
ICL-II	- 44.23
ICL-III	- 54.76
SNL-1	- 60.24
SNL-2	- 70.26
SNL-3	- 205.00

NJ *A 01/89 ( ) New Jersey changed the weighted average for all administratively necessary patient days to $73.06 for SNF and $66.45 for ICF.

NM *A 01/89 (+) New Mexico increased the Institutional Care Program maximum income ceiling by 4% to protect the eligibility of those Institutional Care Program recipients who would otherwise lose their eligibility due to the 4% cost-of-living increase in Social Security benefits. New Mexico also increased the non-covered medical deduction to the Medicare "B" premium standard of $31.90.

OH *A 07/89 ( ) Ohio proposed to change the basis upon which RN, LPN, and nurse aide wages are used in long term care ceiling calculations. The nursing and habilitation/rehabilitation ceilings are calculated as follows.

(1) The local wage component where the long term care facility is located multiplied by minutes (service unit of each resident review service standard) equals dollar values for each standard.

(2) Total dollar values for all Medicaid residents reviewed, for each resident review service standard per month reviewed, divided by the number of person months (one person month equals one resident review for one month) equals the facility ceiling.

Ohio also amended the terms for qualifying for waivers and variances from nursing and habilitation ceilings.

OH *A 07/89 (+) Ohio revised its administrative and general services costs ceiling to the 83rd percentile of aud-

ited costs for ICFs, SNFs, and ICFs/SNFs. In addition, the maximum efficiency incentive was reduced from $2.96 to $2.50 per day.

OH *A 07/89 ( ) Ohio revised reimbursement to ICFs, SNFs, and ICFs/SNFs to 50% of the per diem rate for medically necessary leave days and limited absences. Such days also are counted as 50% of a day for cost reporting purposes.

RI *A 01/89 ( ) Rhode Island established a payroll-specific cost center capped at the 90th percentile for nursing home payment, which includes salaries, wages, and benefits. Caps for previously utilized cost centers were also increased.

VT *A 01/89 (+) Vermont removed the 2-day limit per home visit by nursing home residents. The annual 24 home visit days limit is retained. No payment will be made to nursing homes for days over the 24-day limit. Previously, nursing homes received a reduced payment for days exceeding the limit.

32. ICF/MR SERVICES

A. Amount, Duration and Scope

AZ *A 01/89 (+) Arizona implemented the Arizona Long-Term Care Program (ALTCS) for the elderly and physically disabled. ALTCS uses a prepaid capitated approach to providing LTC services via a managed care system. Services include: SNF, ICF, ICF/MR, HCBS, acute medical services and supplies, and case management.

ID *A 01/89 (+) Idaho increased by 9 the number of reserve bed days for residents of ICFs/MR.

ME *A 07/89 (-) Maine limited reimbursement for day habilitation services to retarded persons from ICFs-MR only, and raised the reimbursement ceiling to $16,500 per client per year. Maine also dropped transportation to and from the day habilitation site.

NM *A 06/89 (+) New Mexico added 9 nursing home reserve bed days for ICF/MR residents as long as the increased absence is documented in the care plan and serves to maintain family and community ties. The additional 9 days allows a total of 15 days.

OK *A 07/89 (+) Oklahoma added coverage of basic need restorative dental care, described under EPSDT, and adaptive equipment (equipment, appliances, and prosthetic devices) beyond the scope of Medicaid for adults and children in private ICFs/MR. Prior authorization is required.

B. Utilization Controls

AL *A 04/89 (-) Alabama added prior authorization by the Mental Health Dept. as a requirement for community mental retardation services in units providing 24-hour personal care to 4 to 15 mentally retarded persons with related conditions.

C. Reimbursement

AL *A 07/89 (-) Alabama began reimbursing ICFs/MR on a reasonable cost basis. Payments will be based on either the lower of the facility's billing rate or maximum re-

imbursement rate, or the facility's usual and customary charge to the general public for the same range of services minus applicable patient income.

AL *A 07/89 (+) Alabama increased the ICF/MR ceiling rate limitation from the 60th percentile to the 90th percentile.

IA *A 03/89 (+) Iowa increased from $75.00 to $130.00 the per diem for the first 3 months of ICF/MR operations.

LA *A 09/89 (-) Louisiana adopted a prospective payment system for ICFs/MR.

33. INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER 22

B. Utilization Controls

AL *A 01/89 (+) Alabama removed the twelve day benefit limit for psychiatric facilities for individuals under age 21 All admissions to psychiatric hospitals for recipients under age 2 require prepayment review.

LA *A 11/89 ( ) Louisiana established certification of need requirements for psychiatric hospitals.

MI *A 10/89 ( ) Michigan amended its contract with the Michigan Peer Review Organization (MPRO) to include certification of Medicaid admissions and continued stays in freestanding private psychiatric hospitals and distinct part psychiatric units of general hospitals. Admissions include elective, urgent, emergent and transfers and readmissions. This process will replace the existing review by the Department of Mental Health and by a more limited MPRO PACER review of selected psychiatric admissions. Admissions authorized by community mental health boards are automatically accepted by MPRO, until the first continued stay review.

C. Reimbursement

CO *A 10/89 (-) Colorado added general acute care hospital psychiatric units to its prospective payment system. One claim is submitted for psychiatric and medical care supplied by the same hospital.

MO *A 01/90 ( ) Missouri established an inpatient psychiatric per diem of $277, based on 110% of the 1988 weighted average cost for non-state operated facilities with free-standing psychiatric units. Psychiatric services are reimbursed at either the lower of the hospital's Medicaid per diem, or the inpatient psychiatric per diem.

34. INSTITUTIONS FOR MENTAL DISEASE FOR INDIVIDUALS 65 & OVER

B. Utilization Controls

AL *A 04/89 (-) Alabama added prior authorization, based on medical necessity, for intermediate care facility services for individuals age 65 or older in mental disease institutions.

CT *A 02/89 ( ) Connecticut established criteria and procedures for facilities "at risk" of being classified as institutions for mental disease (IMD). Criteria for identifying institutions at risk include: facilities with more than 40% of their population diagnosed as psychiatric patients; those with more than 40% of their population transferred from a state mental institution; and those advertising themselves as facilities for treatment of mental disease. At risk facilities are denied approval for new psychiatric admissions until the psychiatric population is below 45% of the facility's Medicaid population, or 50% of the facility's total population. At risk facilities must submit acceptable plans of correction as a condition of continued Medicaid participation. Such facilities are held responsible for any federal financial penalties imposed due to a determination that they are IMDs.

MI *A 10/89 ( ) Michigan amended its contract with the Michigan Peer Review Organization (MPRO) to include certification of Medicaid admissions and continued stays in freestanding private psychiatric hospitals and distinct part psychiatric units of general hospitals. Admissions include elective, urgent, emergent and transfers and readmissions. This process will replace the existing review by the Department of Mental Health and by a more limited MPRO PACER review of selected psychiatric admissions. Admissions authorized by community mental health boards are automatically accepted by MPRO, until the first continued stay review.

37. HOME HEALTH SERVICES

A. Amount, Duration and Scope

AL *A 01/89 (+) Alabama increased its home health visit limitation from 100 to 104 per calendar year.

AZ *A 01/89 (+) Arizona implemented the Arizona Long-Term Care Program (ALTCS) for the elderly and physically disabled. ALTCS uses a prepaid capitated approach to providing LTC services via a managed care system. Services include: SNF, ICF, ICF/MR, HCBS, acute medical services and supplies, and case management.

AR *A 01/90 (-) Arkansas limited home health care visits by a home health nurse, a home health nurse aide, or a combination of the 2 to 25 visits per state, per fiscal year. Additional visits may be approved for children under the EPSDT program.

GA *B 07/89 (-) Georgia proposed establishment of 2 hospital-based home health agency categories: urban hospital-based and rural hospital-based. Their 75th percentile reimbursement cap will be determined by adding an amount to the urban and rural caps for freestanding home health agencies.

The add-on amount will be calculated by determining a mean Medicaid inflated cost per visit for each of the hospital-based categories. For urban hospital-based agencies, the add-on will be equal to 12.29% of the mean cost per visit. For rural-based agencies, the add-on will be equal to 12.86% of the mean cost per visit.

The change is proposed to more accurately reimburse hospital-based home health agencies and is expected to result in annual cost savings of approximately $345,000.

KS *A 07/89 ( ) Kansas dropped home health aide, medical attendant care with registered nurse supervision, and hospice services from its HCBS Program. These services are still offered under Medicaid.

KS *A 04/89 (+) Kansas restored skilled nursing care provided by a licensed practical nurse employed by a home health agency.

KY *A 07/89 (+) Kentucky established reimbursement for out-of-state home health agencies at the lower of the Medicare rate, Medicaid rate, or the agency's actual usual and customary charge. Reimbursement for disposable medical supplies are at 80% of actual usual and customary charges.

ME *A 11/89 (+) Maine redefined homebound clients and their required treatment plans provided through rural health clinics. Homebound clients are confined to their place of residence because of a medical or health condition. Care is provided under a plan of treatment reviewed every 60 days. Rural health clinics may provide services to these individuals in their homes.

ME *A 09/89 (-) Maine now allows either an RN or a licensed occupational therapist to evaluate the physically disabled applying for a HCBS wiaver. Previously, both professionals were required to complete the evaluation.

ME *A 02/89 (-) Maine began excluding from the definition of health care providers municipal entities providing health promotion services in the client's residence and health care facilities serving six clients or fewer

MI *A 05/89 ( ) Michigan allows home health agencies to bill for 2 postpartum/newborn follow-up nurse visits unless the agency also is enrolled as a Maternal Support Services (MSS) provider. MSS providers are reimbursed for follow-up visits as part of a global fee for MSS.

MO *A 11/89 ( ) Missouri added psychiatric nurse services under home health, with a maximum allowable charge per unit of $47.50. These services include patient education and assessment, medication management, and supportive counseling. Psychiatric nursing, considered a skilled nursing service, is covered for recipients meeting home health eligibility criteria and the following conditions:

- o specified diagnoses, including schizophrenic disorders, paranoia, psychosis, and dementia complicated by other disorders;
- o the patient requires active treatment;
- o services are prescribed by a psychiatrist and provided under a care plan reviewed every 60 days by the psychiatrist;

- o services are delivered by a psychiatrically-trained nurse; and
- o the active treatment objectives are measurable by physical criteria.

The services are covered for a 3-week stabilization period, with no more than 2 visits per week. Additional service periods may be approved with documentation of the patient's continued instability. However, these services are subject to the 100 visit per calendar year limit on all home health visits.

MT *A 07/89 (+) Montana redefined homebound for home health agency clients. At the same time, the limit on skilled nursing visits for this group was raised to 365 visits per year and home health aide visits were limited to 12 per year without prior authorization.

NJ *A 05/89 (-) New Jersey added the Home Care Expansion Program which offers the same services as its Community Care Program for the Elderly and Disabled(CCPED); case management home health, homemaker, medical day care, social adult day care, non-emergency, medcal transportation and respite care. HCEP was created for those individuals whose income amd resource standards are above eligibility limits for CCPED. 600 people will be served in 21 counties. The program may require recipients to share in the cost based on the applicants income, cost of services and additional medical or remedial expenses. Non-payment of required cost sharing will result in termination from the program.

OR *A 10/89 (+) Oregon added coverage of home visits to its Maternity Management Services Program.

TN *A 08/89 (+) Tennessee now allows selected supplies, previously available only through home health agencies, to be reimburseable through medical vendors for recipients receiving only supplies, not services. For items necessitating training, suppliers must submit documentation verifying recipient training. The statement must be signed by the recipients or a family member, the physician, or the previous home health agency. This statement is also required from home health agencies for recipients receiving

supplies only. Supplies furnished by a home health agency for "supplies only" receipients must be prior approved.

TX *A 11/89 (+) Texas added coverage of parenteral hyperalimentation in the home for LTC recipients with certain bowel conditions.

B. Utilization Controls

AR *A 02/89 ( ) Arkansas requires a long-term care assessment as part of a request for home health services. The assessment, previously applied only to patients in select counties, is now required statewide.

KS *A 04/89 ( ) Kansas dropped the prior authorization requirement for home apnea monitor rental.

MA *A 03/89 (-) Massachusetts now requires prior authorization for home health aide services exceeding 100 hours per month.

C. Reimbursement

GA *B 01/90 (+) Georgia increased the reimbursement rate by 7% for home health services. Projected annual impact is $6,775,300.

GA *B 01/90 (+) Georgia proposed the following rate changes to the community care services waiver program:

Adult Day Rehabilitation-$40 full day; $24 half day
Homemaker Aide Services - $8 per 1/2 hour;
Alternative Living Services - family and group model personal care home rates - $18.38 per day;
Respite Services - $9 per hour;
Home Delivered Services - 14 percent increase, up to a maximum of 6.13 per visit; and,
Personal Care Aide - $8.27 per 1/2 hour ($700 maximum per month).

The proposed changes are expected to increase aggregate expenditures by $2,827,748.

KY *A 07/89 ( ) Kentucky revised its upper limits for non-public home health agencies as follows:

SERVICE	105% OF MEDIAN
Skilled Nursing	
urban	$69.97

rural	65.60
Physical Therapy	
urban	73.94
rural	71.90
Speech Pathology	
urban	68.65
rural	76.43
Occupational Therapy	
urban	69.55
rural	69.55
Medical Social Services	
urban	92.28
rural	69.71
Home Health Aide	
urban	30.00
rural	24.82

In addition, Kentucky also revised the upper limits for HCBW services as follows:

SERVICE	130% OF MEDIAN
Client Assessment	$64.91
Homemaker	10.82
Personal Care	8.44

Durable medical equipment is no longer reimburseable through the home health agency component.

ME *A 09/89 (+) Maine increased rates for consumer-directed attendant services for the physically disabled as follows:

- o case management services need evaluation $45.00/hour
- o personal care attendant services $ 5.25/hour
- o personal care attendant serivces $10.00/night

ME *A 01/89 (+) Maine increased the unit reimbursement rate for certified nurses aides and home health aides to $5.60 per half hour.

MD *A 07/89 (+) Maryland increased rates for home care case management and nursing services under its model and technology-assisted waivers as follows:

- o waiver enrollment process $1,000.00
- o first month of home care case mngt. $1,000.00

- o second and any subsequent month $ 500.00
- o one hour of home care nursing provided by individual nurse $ 18.00
- o one hour of home care nursing provided by a nursing agency $ 23.40

Maryland also established reimbursement at $40.50 for principal physician's participation in plan of care meetings, including prescribing home care services and approving the plan of care.

MO *A 07/89 (+) Missour increased the maximum allowable fee for home health services from $42.00 to $47.50 per unit

OH *A 05/89 ( ) Ohio began reimbursing home health agencies and nurse-midwives directly for providing at-risk pregnancy services instead of requiring them to be under contract with another provider.

OH *A 04/89 (+) Ohio increased the following fees in addition to the 2% increase which was effective January 13, 1989, because additional funds became available.

-Most practitioner services (as well as the pharmacy dispensing fee, ambulance services, and home health services) rendered on a fee-for-service basis increased by 1.5%.
-Practitioner visits increased by 3%.
-Dental sealants increased to $10 per sealant to promote preventive dental care.
-Additional funds were allocated to address the disparity in reimbursement for brainstem evoked response testing, therapeutic radiology and delivery services.

38. PERSONAL CARE SERVICES

A. Amount, Duration and Scope

AR *A 01/90 (+) Arkansas limited personal care services to 42 hours per month, per recipient. Additional hours may be approved for children under the EPSDT program.

AR *A 01/90 (+) Arkansas limited personal care services to 42 hours per month, per recipient. Additional hours may be approved for children under the EPSDT program.

AR *A 09/89 (+) Arkansas began reimbursing private duty nursing service providers for medical supplies. The $100 per month, per recipient maximum reimbursement for these supplies may be exceeded when appropriately documented.

KS *A 07/89 (+) Kansas began covering residential personal care provided in a licensed residence with prior authorization. Facilities can be "wings" in existing adult care homes or freestanding personal care homes (ten beds or less) in the community. Reimbursement is the amount authorized by field staff up to a maximum of $362 per recipient per month.

KS *A 07/89 (+) Kansas separated its category of medical service, Attendant Care for Independent Living (ACIL) into an adult program and a child program. ACIL is a medical service providing in-home long-term maintenance or supportive care to recipients with special conditions. In January 1990, the adult ACIL Program was dropped.

ME *B 01/90 (+) Maine proposed establishing medical and remedial services provided through the residential care program. These facilities provide services to adults who meet a minimum of one of the following:

- o needs routine supervision in one or more ADLs;
- o needs assistance to manage incontinence;
- o needs medication monitoring or assistance with medical treatment; or

- o needs reminders to initiate or complete independent living activities such as cooking, shopping, banking, and housekeeping.

ME *B 10/89 (-) Maine added a new definition of "family" to be used in determining whether reimbursement for personal care services will be made. Personal care services are not reimburseable to a family member.

The new definition includes: husband or wife; natural or adoptive parent, child, or sibling; step parent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild; spouse of grandparent or grandchild; or grandchild; or any person sharing a common abode as part of a single family unit.

SC *A 00/89 (+) South Carolina added personal care services. Previously, personal care was only covered for HCBS recipients.

WA *A 05/89 (+) Washington added personal care for categorically needy individuals. Services are provided in the recipient's home to the extent that funding is available, with priority given to individuals with the greatest functional disability.

B. Utilization Controls

AR *A 07/89 ( ) Arkansas requires a long-term care assessment as part of a request for personal care services. The assessment, previously applied only to patients in selected counties, is now required statewide.

C. Reimbursement

GA *B 01/90 (+) Georgia proposed the following rate changes to the community care services waiver program:

Adult Day Rehabilitation-$40 full day; $24 half day
Homemaker Aide Services - $8 per 1/2 hour;
Alternative Living Services - family and group model personal care home rates - $18.38 per day;
Respite Services - $9 per hour;
Home Delivered Services - 14 percent increase, up to a maximum of 6.13 per visit; and,
Personal Care Aide - $8.27 per 1/2 hour ($700 maximum per month).

The proposed changes are expected to increase aggregate expenditures by $2,827,748.

KY *A 07/89 (+) Kentucky increased the upper limits for the following outpatient services:

o psychosocial rehabilitation services (partial hospitalization)	$ 8.27
o outpatient (clinical)	14.15
o personal care (off-site)	3.09
o inpatient (off-site)	20.28

ME *A 09/89 (+) Maine granted the consumers of home and community-based waiver services for the phycially disabled authority to hire, train, and supervise their personal care attendants. Consumers who are unable to manage personal care attendants are terminated from the program.

ME *A 09/89 (+) Maine increased rates for consumer-directed attendant services for the physically disabled as follows:

o case management services need evaluation	$45.00/hour
o personal care attendant services	$ 5.25/hour
o personal care attendant serivces	$10.00/night

MO *A 01/89 (+) Missouri increased reimbursement for personal care and homemaker/chore services from $7.10 to $7.24 per unit of aide service. In July, the rate was increased to $7.56.

39. CASE MANAGEMENT

A. Amount, Duration and Scope

AK *A 01/89 (+) Alaska added case management for high-risk pregnant women. The experimental program was begun in 5 specified areas of the state.

AZ *A 01/89 (+) Arizona implemented the Arizona Long-Term Care Program (ALTCS) for the elderly and physically disabled. ALTCS uses a prepaid capitated approach to providing LTC services via a managed care system. Services include: SNF, ICF, ICF/MR, HCBS, acute medical services and supplies, and case management.

AR *A 10/89 (+) Arkansas added the following services to the child
KS *A 10/89 (-) Kansas added targeted case management for severely emotionally disturbed children and adolescents up to 150 hours per calendar year.

LA *A 06/89 (-) Louisiana added case management for 3 new groups: chronically mentally ill, pregnant women, and HIV-disabled individuals.

ME *A 07/89 (-) Maine added case management for persons with HIV infection. Services may be provided by social workers, RNs, or other qualified staff with a maximum allowance of $28.04 per week. A quality assurance program for these services will be implemented.

NM *A 12/89 (-) New Mexico implemented case management services for the chronically mentally ill. These services will first be implemented in Dona Ana county on a pilot basis, to evaluate the effectiveness of the service and to monitor caseload size and cost. Additiional pilot areas will be phased-in over a 2-3 month period.

PA *A 11/89 (-) Pennsylvania added case management for AIDS patients.

WA *A 08/89 (+) Washington expanded eligibility for pregnant women and infants up to 185% of poverty. In addition, eligibility was extended to children up to age 8 in families with incomes up to 100% of poverty. Both actions were part of Washington's First Steps Program, which also includes case management for high-risk recipients, maternity support services, increased maternity provider fees, and new fees for

risk assessment and high-risk pregnancies. The program includes state-only funds to allow access for non-Medicaid women.
Medicaid also participates in identification of maternity distressed areas and works with the identified counties to develop alternative delivery systems for their residents.

B. Utilization Controls

KY *A 03/89 ( ) Kentucky dropped its initial home assessment requirement for:

- o certain home health orthotic appliances under $100 accompanied by a physician's order and a treatment plan; and
- o cases when the agency is already knowledgeable about the patient's needs and home situation through previous or present contact.

C. Reimbursement

ME *A 04/89 (+) Maine increased the maximum allowance for case management to $30.00 per half hour and for adult day health to $6.00 per half hour.

40. HOSPICE

A. Amount, Duration and Scope

AZ *A 01/89 (-) Arizona added hospice coverage.

KS *A 07/89 ( ) Kansas dropped home health aide, medical attendant care with registered nurse supervision, and hospice services from its HCBS Program. These services are still offered under Medicaid.

KS *A 06/89 (-) Kansas added hospice coverage.

KY *A 01/89 (+) Kentucky removed the 210 day limit for hospice coverage. The attending physician or hospice medical director must continue to certify that the patient's life expectancy is 6 months or less.

MD *A 10/89 (-) Maryland added hospice services administered by Medicare-certified providers. Maryland's hospice program uses the Medicare benefit periods and aggregate payment cap.

MO *A 05/89 (-) Missouri added coverage of hospice services with 90-day benefit periods. Drug prescription limits do not apply to hospice patients.

MT *A 07/89 (-) Montana added hospice coverage utilizing the Medicare benefit period guidelines and an aggregate payments cap.

* NM *A 01/89 (-) New Mexico added coverage of hospice services.

PA *A 03/89 (-) Pennsylvania added hospice coverage.

WA *A 07/89 (-) Washington added hospice services.

C. Reimbursement

MI *A 01/89 ( ) Michigan modified its hospice program to allow separate billing for AZT. Previously, hospices were required to provide all services to their patients. Now, pharmacies may be reimbursed separately for AZT.

NY *A 11/89 (+) New York supplements hospice reimbursement for persons with AIDS or other illnesses requiring a more costly or intensive level of care than typically provided.

41. OTHER COMMUNITY-BASED LONG TERM CARE SERVICES

A. Amount, Duration and Scope

AZ *A 01/89 (+) Arizona implemented the Arizona Long-Term Care Program (ALTCS) for the elderly and physically disabled. ALTCS uses a prepaid capitated approach to providing LTC services via a managed care system. Services include: SNF, ICF, ICF/MR, HCBS, acute medical services and supplies, and case management.

KS *A 07/89 ( ) Kansas separated its category of medical service, Attendant Care for Independent Living (ACIL) into an adult program and a child program. ACIL is a medical service providing in-home long-term maintenance or supportive care to recipients with special conditions. In January 1990, the adult ACIL Program was dropped.

C. Reimbursement

KY *A 07/89 ( ) Kentucky revised its upper limits for non-public home health agencies as follows:

SERVICE	105% OF MEDIAN
Skilled Nursing	
urban	$69.97
rural	65.60
Physical Therapy	
urban	73.94
rural	71.90
Speech Pathology	
urban	68.65
rural	76.43
Occupational Therapy	
urban	69.55
rural	69.55
Medical Social Services	
urban	92.28
rural	69.71
Home Health Aide	
urban	30.00
rural	24.82

In addition, Kentucky also revised the upper limits for HCBW services as follows:

SERVICE	130% OF MEDIAN
Client Assessment	$64.91
Homemaker	10.82

Personal Care 8.44

Durable medical equipment is no longer reimburseable through the home health agency component.


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2. THIRD PARTY LIABILITY

AL *A 01/89 (-) Alabama Medicaid will pay dually certified facilities the coinsurance amounts for the first eight days of skilled level care. No payment will be made by Medicaid for the 9th day through the 150th day for Medicare eligible patients. Medicare covers up to 150 days of skilled nursing care services in a calendar year.

AL *A 01/89 (+) Alabama extended coverage to QMBs up to 85% of poverty. Coinsurance payments for their non-Medicaid services are made up to Medicaid payment levels.

AL *A 01/89 (+) Alabama makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicaid payment levels.

AK *A 02/89 (+) Alaska extends coverage to QMBs up to 100% of poverty. Deductible and coinsurance payments on their non-Medicaid services are made at Medicaid payment levels.

AZ *A 07/89 (+) Arizona makes coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels.

AR *A 03/89 (+) Arkansas makes deductible and coinsurance payments for QMBs' Medicaid services up to Medicare payment levels.

CA *A 01/90 (+) California makes deductible and coinsurance payments on QMBs' non-Medicaid services up to Medicaid payment rates.

CT *A 01/89 (+) Connecticut makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels.

FL *A 01/89 (+) Florida extended coverage to QMBs up to 100% of poverty. Deductibles and coinsurance payments for their non-Medicaid services are made at the Medicaid payment level.

HI *A 07/89 (+) Hawaii extended coverage to QMBs up to 100% of poverty. For non-Medicaid services, coinsurance payments will be made at the Medicare payment level.

ID *A 01/89 (+) Idaho makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels.

IL *A 07/89 (+) Illinois makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels. In Illinois, QMBs are only covered up to 80% of poverty because of federal legislation allowing them a more gradual phase-in of this group

IN *A 02/89 (+) Indiana makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels. In Indiana, QMBs are only covered up to 80% of poverty due to federal legislation allowing the state a more gradual phase-in of this group

IA *A 01/89 (+) Iowa makes deductible and coinsurance payments on behalf of QMBs up to Medicaid payment levels.

KY *A 05/89 (+) Kentucky added DME. Prior authorization is required for DME items over $150 and for DME recipients who have other third party coverage (excluding Medicare). Disposable medical supplies are limited to those currently reimbursable by Medicare. Also, as of July, 1989, DME suppliers can no longer bill through the home health system.

KY *A 03/89 (+) Kentucky Medicaid elected to cover all Medicare deductible and coinsurance amounts for those individuals who are both Medicare and Medicaid eligible, but not QMB eligible.

KY *A 01/89 (+) Kentucky makes deductible and coinsurance payments for QMBs' Medicaid services up to Medicare levels.

ME *A 00/89 (+) Maine makes deductible and coinsurance payments on QMBs' non-Medicaid services up to Medicare levels.

MA *A 01/89 ( ) Massachusetts now requires that all Medicaid providers participate in all components of the Common-Health Program, the state health insurance program.

MI *A 06/89 (+) Michigan makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels.

MS *A 10/89 (+) Mississippi increased the inpatient hospital days to a maximum of 30 days per fiscal year for adults. Inpatient physician visits also were increased from 15 to 30 per fiscal year. When approved by the PRO children under age 21 are allowed unlimited inpatient days when in DSHs, and in non-DSHs for specified diagnoses. A $5 per day copayment is required in certain instances. For Medicare/Medicaid eligibles, Medicare deductibles are paid, but the allowable days are reduced to Medicaid lengths of stay.

MS *A 07/89 (+) Mississippi extended coverage to the aged, blind, and disabled up to 85% of poverty, using the OBRA 1986 option. In January 1990, the percentage of poverty increased to 90%, continuing to parallel the QMB income standard. Deductible and coinsurance payments for QMBs' non-Medicaid services are made up to Medicare payment levels.

MO *A 06/89 (+) Missouri makes deductible and copayments for QMBs' non-Medicaid services up to Medicare payment levels.

NE *A 01/89 (+) Nebraska makes deductible and coinsurance payments on QMBs' non-Medicaid services up to Medicaid payment levels.

NV *A 03/89 (+) Nevada extended coverage to QMBs up to 100% of povty. Deductible and coinsurance payments for their non-Medicaid services are made up to Medicaid icaid levels.

NH *A 01/89 (+) New Hampshire makes deductible and coinsurance payments on QMBs' Medicare but non-Medicaid covered services up to Medicare payment levels.

NJ *A 06/89 (+) New Jersey began paying Part A premiums for QMBs with incomes up to 100% of poverty. Previously, New Jersey had covered this poulation for all Medicaid services, for Medicare coinsurance and deductible up to the Medicaid allowable, and for Part B premium.

NM *A 01/89 (+) New Mexico makes coinsurance payments on QMBs non-Medicaid services up to Medicaid payment levels.

NY *A 06/89 (+) New York extended coverage to QMBs up to 100 percent of poverty. Deductibles and coinsurance payments on non-Medicaid services are made up to Medicaid payment levels, except for ambulance services which are paid up to Medicare payment levels.

NC *A 01/89 (+) North Carolina makes deductible and coinsurance payments on QMBs' non-Medicaid services up to Medicare payment levels. In North Carolina, QMBs are only covered up to 80% of poverty because of federal legislation allowing a more gradual phase-in of this group.

OH *A 01/89 (+) Ohio makes coinsurance payments on QMBs' non-Medicaid services up to Medicaid payment levels. In Ohio, QMBs are only covered up to 80% of poverty because of federal legislation permitting a more gradual phase-in of this group.

OK *A 01/89 (+) Oklahoma extended coverage to QMBs up to 90% of poverty. Deductible and coinsurance payments on their non-Medicaid services are made up to Medicaid payment levels.

OR *A 09/89 (+) Oregon makes deductible and coinsurance payments on QMBs' and other dual-eligibles' non-Medicaid services up to Medicaid payment levels.

SC *A 10/89 (+) South Carolina extended eligibility to QMBs up to 100% of poverty. Deductible and coinsurance payments on their non-Medicaid services are made up to Medicare payment levels.

TN *A 01/89 (+) Tennessee makes deductible and coinsurance payments on QMBs' non-Medicaid services up to Medicare payment levels.

TX *A 01/89 (+) Texas makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels.

UT *A 06/89 (+) Utah extended eligibility to QMBs up to 100% of poverty. Deductible and coinsurance payments for their non-Medicaid services are made at the Medicaid payment level.

VT *A 06/89 (+) Vermont extended eligibility to QMBs up to 86% of poverty in 1989, increasing to 91% of poverty in January 1990. Deductibles and coinsurance payments on their non-Medicaid services are made up to Medicaid payment levels.

VA *A 01/89 (+) Virginia makes coinsurance payments on QMBs' non-Medicaid services up to Medicare payment levels.

WA *A 02/89 (+) Washington makes coinsurance payments on QMBs' non-Medicaid services up to Medicare payment levels.

WV *A 01/89 (+) West Virginia makes deductible and coinsurance payments on behalf of QMBs at Medicare payment levels.

WI *A 09/89 (+) Wisconsin extended coverage to QMBs up to 100% of poverty. Deductible and coinsurance payments for Medicare but non-Medicaid covered services are made up to the Medicaid payment level.

WY *A 06/89 (+) Wyoming makes deductible and coinsurance payments for QMBs' non-Medicaid services at the Medicaid payment level.

4. CLAIMS PROCESSING

NJ *A 02/89 ( ) New Jersey increased the upper limit for submission of routine prescription drug claims from $99.00 to $199.00.





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III. ELIGIBILITY

1. COVERAGE OF OPTIONAL GROUPS

AZ *A 10/89 (+) Arizona expanded eligibility to children up to age 7 who are in families with incomes up to poverty.

DE *A 11/89 (+) Delaware extended eligibility to disabled adults who were SSI recipients as children, but are no longer SSI eligible.

DE *A 11/89 (+) Delaware added coverage of infants in foster care awaiting adoption through private agencies.

IA *A 07/89 (+) Iowa increased the income limit for pregnant women and infants from 150% to 185% of the poverty level. In addition, Iowa increased the age limit for children from up to age 2 to up to age 8.

IA *A 01/89 (+) Iowa added caretaker relatives to its medically needy coverage groups. Caretaker relatives are persons who would be eligible for ADC as a "specified relative" except for income or resources. Previously the caretaker relatives' medical expenses were counted for meeting spenddown; now the caretaker may be eligible or conditionally eligible for Medicaid. This change will not affect CMAP-related medically needy cases where the family unit is intact.

ME *A 07/89 (-) Maine limited reimbursement for day habilitation services to retarded persons from ICFs-MR only, and raised the reimbursement ceiling to $16,500 per client per year. Maine also dropped transportation to and from the day habilitation site.

MN *A 06/89 (+) Minnesota expanded eligibility to children age 1 through 7 in families with income up to poverty.

MS *A 10/89 (-) Mississippi extended eligibility to disabled children under age 18 who can be appropriately and cost-effectively cared for at home.

NY *A 01/89 (+) New York changed its eligibility criteria for parents age 21 through 64 who live with their dependent children. If their income exceeds AFDC standards, but not Medicaid income and resource standards, these individuals will not be eligible for

full medical assistance, without spenddown, under the same eligiblity standards as their children. This group was dropped in October 1989.

NC *A 10/89 (+) North Carolina expanded coverage for children up to age 6 in families with incomes up to poverty.

NC *A 07/89 (+) North Carolina expanded coverage for children under age 3 up to poverty.

2. INCOME LEVELS

AL *A 01/89 (+) Alabama extended coverage to QMBs up to 85% of poverty. Coinsurance payments for their non-Medicaid services are made up to Medicaid payment levels.

AK *A 01/90 (+) Alaska increased its AFDC monthly need standards as follows:

FAMILY SIZE	MONTHLY NEED
1	$473
2	752
3	846
4	940

AK *A 02/89 (+) Alaska extends coverage to QMBs up to 100% of poverty. Deductible and coinsurance payments on their non-Medicaid services are made at Medicaid payment levels.

CA *A 06/89 (+) California extended eligibility to include pregnant women and infants with family incomes up to 185% of poverty.

CT *A 01/89 (+) Connecticut extended eligibility to pregnant women and infants in families up to 185% of poverty. This group is not subject to an assests test.

DE *A 07/89 (+) Delaware added coverage of children up to age 2 in families with incomes up to 100% of poverty.

DE *A 01/89 (+) Delaware extends coverage to QMBs up to 100% of poverty.

FL *A 01/89 (+) Florida increased the monthly income standard for the institutionalized to 300 percent of the supplemental security income benefit ($354). The standard increased from $1,062 to $1,104 per month.

FL *A 01/89 (+) Florida extended coverage to QMBs up to 100% of poverty. Deductibles and coinsurance payments for their non-Medicaid services are made at the Medicaid payment level.

GA *A 01/89 (+) Georgia extended coverage to pregnant women and children under age 3 up to the federal poverty level.

HI *A 07/89 (+) Hawaii extended coverage to QMBs up to 100% of poverty. For non-Medicaid services, coinsurance payments will be made at the Medicare payment level.

HI *A 01/89 (+) Hawaii added coverage of pregnant women and infants up to 100% of poverty. Effective January 1, 1990, the income threshold will rise to 185% of poverty.

HI *A 01/89 (+) Hawaii added coverage for the elderly and disabled up to 100% of poverty. Therefore, QMBs up to 180% of poverty also are covered.

HI *A 01/89 (+) Hawaii extended coverage to children age 1 through 7 who are in families with incomes up to 100% of poverty.

ID *A 01/89 (+) Idaho extended eligibility to pregnant women and infants up to 67% of poverty.

IL *A 07/89 (+) Illinois makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels. In Illinois, QMBs are only covered up to 80% of poverty because of federal legislation allowing them a more gradual phase-in of this group

IN *A 02/89 (+) Indiana makes deductible and coinsurance payments for QMBs' non-Medicaid services up to Medicare payment levels. In Indiana, QMBs are only covered up to 80% of poverty due to federal legislation allowing the state a more gradual phase-in of this group

IA *A 07/89 (+) Iowa increased the income limit for pregnant women and infants from 150% to 185% of the poverty level. In addition, Iowa increased the age limit for children from up to age 2 to up to age 8.

IA *A 07/89 (+) Iowa revised its medically needy income levels as follows.

NUMBER OF PERSONS	MEDICALLY NEEDY INCOME LEVELS
1	$466.00
2	466.00
3	550.00
4	633.00
5	708.00

	6	783.00
	7	858.00
	8	941.00

IA *A 01/89 (+) Iowa established a $65.00 deduction for a person in a SNF or ICF, in addition to the ongoing $30.00 deduction for personal needs. The total $95 deduction is allowed even if the individual has earned income.

IA *A 01/89 ( ) Iowa increased from 2 months to 6 months the certification period for medically needy individuals in households with no spenddown.

IA *A 01/89 (+) Iowa increased the personal needs allowance for residential care facility residents to $48 per month. In January 1990, the allowance was increased again to $50 per month.

LA *A 06/89 (+) Louisiana has revised its personal needs allowance to $38.00 for individuals and $76 for couples.

LA *A 02/89 (+) Louisiana implemented an income disregard of the first $65, and one-half of the remaining amount of the gross monthly income derived from an income-producing activity, prescribed by the physician's care plan, to be deducted from the total gross monthly income applied toward the recipient's liability for payment of LTC facility services.

LA *A 01/89 (-) Louisiana expanded eligibility for pregnant women and infants, and children up to age eight in families with incomes up to 100% of poverty. Presumptive eligbility for pregnant women also was implemented.

MA *A 06/89 (+) Massachusetts extended coverage to QMBs up to 100% of poverty.

MN *A 05/89 (+) Minnesota makes deductible and coinsurance payments for QMBs' non-Medicaid services at Medicare payment levels.

MS *A 10/89 (+) Mississippi extended eligibility to pregnant women and infants up to 185% of poverty.

MS *A 07/89 (+) Mississippi extended coverage to the aged, blind, and disabled up to 85% of poverty, using the OBRA 1986 option. In January 1990, the percentage of poverty increased to 90%, continuing to parallel the QMB income standard. Deductible and coinsurance payments for QMBs' non-Medicaid services are made up to Medicare payment levels.

NV *A 07/89 (+) Nevada extended eligibility to children up to age 6 in families with incomes up to the AFDC income threshold. In addition the resource test was dropped for this group, as well as for pregnant women and infants.

NV *A 03/89 (+) Nevada extended coverage to QMBs up to 100% of povty. Deductible and coinsurance payments for their non-Medicaid services are made up to Medicaid icaid levels.

NH *A 01/89 (+) New Hampshire increased the income "CAP" level for nursing home care eligibility by 4.0%, to $931.

NH *A 01/89 (+) New Hampshire increased its medically needy protected income level (PIL) twice, as follows:

EFF. 1/1/89		EFF. 7/1/89	
GROUP SIZE	PIL	GROUP SIZE	PIL
1	382	1	382
2	554	2	554
3	571	3	575
4	589	4	597

NJ *A 06/89 (+) New Jersey began paying Part A premiums for QMBs with incomes up to 100% of poverty. Previously, New Jersey had covered this poulation for all Medicaid services, for Medicare coinsurance and deductible up to the Medicaid allowable, and for Part B premium.

NM *A 06/89 (+) New Mexico excluded for purposes of eligibility determination the portion of a Veteran's Administration Improved Pension (VAIP) intended for unreimbursed medical expenses. However, the entire amount of the VAIP benefit will be counted for purposes of computation of the medical care credit.

NM *A 06/89 (+) New Mexico extended eligibility to children up to age 4 in families with poverty-level incomes. Children up to age 7 in families with AFDC-level incomes also were added.

NY *A 01/90 (+) New york revised its 1990 income standards for its consolidated services plan as follows:

FAMILY SIZE	INCOME STANDARDS (PER MONTH)
1	$ 550.33
2	$ 719.66
3	$ 889.00
4	$1,058.33
5	$1,227.66
6	$1,397.00
Each additional number	Add $62.50

The standards are developed by using the federal poverty level for a family of 4, and then adjusting for family size.

NY *A 01/90 (+) New York revised its income standards and personal needs allowances for recipients residing in certified congregate care level I and II facilities.

LEVEL I FAMILY CARE	PA STANDARD OF CARE	PNA	TOTAL PA STANDARDS OF ASSISTANCE
NYC, Nassau, Suffolk & Westchester counties	$559.96	$75	$634.96
Rest of state	$521.96	$75	$596.96

LEVEL II RESIDENTIAL CARE	PA STANDARD FOR CARE	PNA	TOTAL PA STANDARDS OF ASSISTANCE
NYC, Nassau, Suffolk & Westchester counties	$736.00	$85	$821.00
Rest of state	$706.00	$85	$791.00

NY *A 06/89 (+) New York extended coverage to QMBs up to 100 percent of poverty. Deductibles and coinsurance payments on non-Medicaid services are made up to Medicaid payment levels, except for ambulance services which are paid up to Medicare payment levels.

NY *A 01/89 (+) New York increased state supplementary payments commensurate with federal cost of living increase to SSI recipients. State supplementary payments for individuals living alone increased from $71.91 to $86 per month, for couples living alone form $92.53 to $102.50 per month. For individuals living with others from $17.24 to $23 per month and for couples living with others from $40.53 to $45.00.

NY *A 01/89 (+) New York increased the MAO applicants/recipients income and resource standards in January 1989 and January 1990 as follows:

MAO INCOME STANDARDS

NUMBER OF PERSONS	ANNUAL 1/89	ANNUAL 1/90	MONTHLY 1/89	MONTHLY 1/90
1	5,500	5,700	459	475
2	7,900	8,200	659	684
3	8,500		709	
4	10,200		850	
5	11,900		992	
6	13,600		1,734	
7	15,300		1,275	
8	17,000		1 417	

MAO RESOURCE STANDARDS

NUMBER OF PERSONS	RESOURCE STANDARD 1/89	RESOURCE STANDARD 1/90
1	3,250	3,350
2	4,950	5,100
3	5,750	
4	7,100	
5	7,950	
6	8,800	
7	9,650	
8	10,500	

NY *A 01/89 (+) New York established a maximum SSI payment of $454.00 for individuals living alone, and $655.50 for couples living alone, exceeding the federal requirement. In January 1990, these payments were increased to $472 for individuals and $681.50 for couples.

NC *A 01/90 (+) North Carolina increased categorically needy and medically needy income levels by 2%. However, due to federal rounding requirements, the income standard for 1 person did not increase.

NUMBER OF PERSONS	EFF. 1/1/88 (PER MONTH)	EFF. 1/1/90 (PER MONTH)
1	$242	$242
2	308	317
3	358	367
4	392	400
5	425	433
6	458	467

NC *A 01/89 (+) North Carolina makes deductible and coinsurance payments on QMBs' non-Medicaid services up to Medicare payment levels. In North Carolina, QMBs are only covered up to 80% of poverty because of federal legislation allowing a more gradual phase-in of this group.

OH *A 01/89 (+) Ohio makes coinsurance payments on QMBs' non-Medicaid services up to Medicaid payment levels. In Ohio, QMBs are only covered up to 80% of poverty because of federal legislation permitting a more gradual phase-in of this group.

OK *A 01/89 (+) Oklahoma extended coverage to QMBs up to 90% of poverty. Deductible and coinsurance payments on their non-Medicaid services are made up to Medicaid payment levels.

PA *A 11/89 (+) Pennsylvania extended eligibility to QMBs up to 100% of poverty.

RI *A 07/89 (+) Rhode Island added coverage of children from age 1 up to age 8, when in families with incomes up to the poverty level.

SC *A 12/89 (+) South Carolina allows institutionalized individuals to deduct from their monthly recurring incomes certain medical expenses not covered by Medicaid or third party payers. Monthly recurring income is the amount of income that must be contributed toward institutional care costs. Allowable deductions include:

- o health insurance premiums;
- o prescription drugs over the 4 per month limit, not to exceed $12 per additional prescription;
- o eyeglasses not covered by Medicaid, up to $70 per occurrence for lenses, frames, and dispensing fee;
- o dentures, once per lifetime, up to $225 per plate or $450 for one full pair;

- o denture repair up to $37 per occurrence;
- o physician and other medical practitioner visits over the 18 visit per year limit, not to exceed $20 per visit;
- o hearing aids, once per lifetime, up to $380; and
- o other non-covered expenses up to $20 per item or service.

SC *A 10/89 (+) South Carolina extended eligibility to the aged, blind, and disabled with incomes up to 100% of poverty using the OBRA 1986 authority.

SC *A 10/89 (+) South Carolina extended eligibility to QMBs up to 100% of poverty. Deductible and coinsurance payments on their non-Medicaid services are made up to Medicare payment levels.

SC *A 10/89 (+) South Carolina expanded eligibility for children under age 7 in families with income up to poverty.

SC *A 06/89 (+) South Carolina expanded eligibility for pregnant women and infants up to 185% of poverty.

SC *A 04/89 (+) South Carolina expanded eligibility to pregnant women and infants up to 125% of poverty. Previously, this group was covered up to 100% poverty.

SC *A 04/89 (+) South Carolina expanded eligibility to children up to age 6 in families with incomes up to poverty.

TX *A 09/89 (+) Texas increased its income standard for institutionalized individuals to 300% of the SSI income standard.

TX *A 01/89 (-) Texas increased the Fair Standard Contribution due from an ineligible spouse toward the care of an institutionalized spouse from $410 to $426.

TX *A 01/89 ( ) Texas changed the countable income limit for medical assistance only eligibility to $715 for an individual and $1430 for a couple.

UT *A 01/89 (+) Utah extended eligibility to QMBs up to 100% of poverty. Deductible and coinsurance payments for their non-Medicaid services are made at the Medicaid payment level.

UT *A 01/89 (+) Utah extended eligibility to pregnant women and infants in families up to 100% of poverty.

VT *A 07/89 (+) Vermont implemented its Prenatal and Children's Health Program to provide prenatal care for pregnant women between 185% and 200% of poverty who do not have insurance. It also will provide Medicaid-equivalent services to uninsured children under age 7 up to 225% of poverty who are ineligible for Medicaid.

No resource test is used in determining eligibility Copayments, varying according to family income, for well-child office visits are as follows:

% OF POVERTY INCOME	COPAYMENT
100 - 149%	$2.00
150 - 199%	3.00
200 - 225%	5.00

VT *A 07/89 (+) Vermont changed the basic need standards and maximum housing allowances for determining AFDC eligibility to reflect 1988 cost of living changes.

VT *A 07/89 ( ) Vermont reduced the ratable deduction used to calculate the payment and income standard for AFDC families. The rate was reduced from 68 to 67% as a measure to meet budget constraints. The reduction rate will increase on Oct. 1, 1989 to 67.5%, and on January 1, 1990 to 68.1%.

VT *A 06/89 (+) Vermont extended eligibility to QMBs up to 86% of poverty in 1989, increasing to 91% of poverty in January 1990. Deductibles and coinsurance payments on their non-Medicaid services are made up to Medicaid payment levels.

WA *A 08/89 (+) Washington expanded eligibility for pregnant women and infants up to 185% of poverty. In addition, eligibility was extended to children up to age 8 in families with incomes up to 100% of poverty. Both actions were part of Washington's First Steps Program, which also includes case management for high-risk recipients, maternity support services, increased maternity provider fees, and new fees for risk assessment and high-risk pregnancies. The program includes state-only funds to allow access for non-Medicaid women.
Medicaid also participates in identification of ma-

ternity distressed areas and works with the identified counties to develop alternative delivery systems for their residents.

WI *A 09/89 (+) Wisconsin extended coverage to QMBs up to 100% of poverty. Deductible and coinsurance payments for Medicare but non-Medicaid covered services are made up to the Medicaid payment level.

3. RESOURCE STANDARDS/RULES

AK *A 02/89 (+) Alaska set its community spouse resource allowance minimum at $60,000.

CO *A 01/90 (-) Colorado added presumptive eligibility for pregnant women and infants.

CO *A 07/89 (+) Colorado set its community spouse resource allowance minimum at $60,000.

CT *A 10/89 (-) Connecticut added coverage of air transportation if it is less expensive than alternative means of transportation. In addition, coverage of a critical care helicopter is covered if its utilization is medically or financially justifiable over ground transportation based on state-specified criteria. Payments for transportation are not made to relatives or foster parents of a hospital inpatient, unless the relative requires training to provide unpaid health care in the home to the recipient.

CT *A 01/89 (+) Connecticut extended eligibility to pregnant women and infants in families up to 185% of poverty. This group is not subject to an assests test.

DE *A 11/89 ( ) Delaware set its community spouse resource allowance minimum at $60,000.

FL *A 10/89 (+) Florida set its community spouse resource limit at $60,000.

HI *A 07/89 (+) Hawaii set the community spouse resource allowance minimum at $60,000.

HI *A 01/89 (+) Hawaii added presumptive eligibility for pregnant women.

HI *A 01/89 (+) Hawaii added presumptive eligibility for pregnant women.

HI *A 01/89 (+) Hawaii added continuous eligibility for pregnant women and infants. The women and infants are covered for 60 days postpartum without regard to any increase in income.

ID *A 01/89 (+) Idaho added presumptive eligibility for pregnant women.

ID *A 01/89 (+) Idaho added continuous eligibility for pregnant women and infants. Women are covered through 60 days postpartum; infants for one year.

IA *A 01/90 (+) Iowa added presumptive eligibility for pregnant women.

IA *A 07/89 (+) Iowa established continuous eligibility for pregnant women.

IA *A 07/89 (+) Iowa increased the resource limit for its mothers and children (MAC) coverage group from $5,000 for one person and $7,500 for 2 or more to $10,000 per household, regardless of size.

IA *A 07/89 (+) Iowa redefined countable resources considered in determining eligibility for poverty-level pregnant women, infants, and children to match the definition used by its Indigent Obstetrical Care Program. The O.B. Indigent Care Program only considers monetary resources and Medicaid qualifying trusts as countable resources.

IA *A 01/89 (+) Iowa added caretaker relatives to its medically needy coverage groups. Caretaker relatives are persons who would be eligible for ADC as a "specified relative" except for income or resources. Previously the caretaker relatives' medical expenses were counted for meeting spenddown; now the caretaker may be eligible or conditionally eligible for Medicaid. This change will not affect CMAP-related medically needy cases where the family unit is intact.

IA *A 01/89 (+) Iowa increased medically needy resource standards to $5,000 for individuals and $7,500 for 2 or more people.

KY *A 06/89 (+) Kentucky set its community spouse resource allowance minimum at $60,000.

LA *A 01/89 (-) Louisiana expanded eligibility for pregnant women and infants, and children up to age eight in fami-

lies with incomes up to 100% of poverty. Presumptive eligbility for pregnant women also was implemented.

MD *A 07/89 (+) Maryland raised the age limit from 19 to 22 for initial eligibility for model and technology-assisted waivers. In addition, the age 22 limit for continued participation in the waiver was dropped. dropped.

MD *A 07/89 (+) Maryland expanded coverage of pregnant women and infants up to 185% of poverty.

MN *A 07/89 (+) Minnesota removed the $2,000 limit on the exclusion of household goods and personal effects from its eligibility determination.

MS *A 10/89 (+) Mississippi set its community spouse resource allowance minimum at $60,000.

MO *A 01/89 (+) Missouri established a streamlined application process for adding newborns born to Medicaid women. Coverage for the infant begins with the date of birth and extends through the month of the child's first birthday. During this time, the mother must remain eligible, and the child must live with the mother. No formal application is filed for the child; however, the family services organization is responsible for verification of birth and eligibility information.

NV *A 07/89 (+) Nevada extended eligibility to children up to age 6 in families with incomes up to the AFDC income threshold. In addition the resource test was dropped for this group, as well as for pregnant women and infants.

NH *A 07/89 (-) New Hampshire established in January a new coverage group, Children with Severe Disabilities (CSD). Children must be under age 18, meet medical disability criteria, and AFDC income and resource requirements with parental deeming.
In addition, New Hampshire added home care for CSDs who can be served cost-effectively at home.

NM *A 04/89 (+) New Mexico added presumptive eligibility for pregnant women.

NM *A 01/89 (+) New Mexico set its community spouse resource allowance minimum at $30,000.

NY *A 12/89 (+) New York set its community spouse resource allowance minimum at $60,000.

NY *A 01/89 (+) New York increased the MAO applicants/recipients income and resource standards in January 1989 and January 1990 as follows:

MAO INCOME STANDARDS

NUMBER OF PERSONS	ANNUAL 1/89	ANNUAL 1/90	MONTHLY 1/89	MONTHLY 1/90
1	5,500	5,700	459	475
2	7,900	8,200	659	684
3	8,500		709	
4	10,200		850	
5	11,900		992	
6	13,600		1,734	
7	15,300		1,275	
8	17,000		1 417	

MAO RESOURCE STANDARDS

NUMBER OF PERSONS	RESOURCE STANDARD 1/89	RESOURCE STANDARD 1/90
1	3,250	3,350
2	4,950	5,100
3	5,750	
4	7,100	
5	7,950	
6	8,800	
7	9,650	
8	10,500	

NC *A 07/89 (+) North Carolina established a one calendar month base period for determining financial eligibility for pregnant women.

OK *A 10/89 (+) Oklahoma set its community spouse resource allowance minimum at $25,000.

RI *A 10/89 (+) Rhode Island set its community spouse resource allowance minimum at $60,000.

SC *A 09/89 (+) South Carolina set its community spouse resource allowance minimum at $60,000.

TN *A 02/89 (+) Tennessee implemented presumptive eligibility through the local health department for pregnant women up to the poverty level.

TX *A 11/89 (+) Texas added presumptive eligibility for pregnant women. The services covered during the presumptive period are limited to medically necessary services with the exception of labor, delivery, inpatient services, and EPSDT medical and dental services.

VT *A 10/89 (+) Vermont set its community spouse resource allowance minimum at $60,000.

VT *A 07/89 ( ) Vermont eliminated the resource test for eligibility for pregnant women and children born after September 30, 1983.

WA *A 10/89 (+) Washington set its community spouse resource allowance minimum at $60,000.

WI *A 08/89 (+) Wisconsin increased the community spouse resource limit to $60,000 from $15,000.

4. OTHER ELIGIBILITY CHANGES

IA *A 01/89 (+) Iowa increased medically needy resource standards to $5,000 for individuals and $7,500 for 2 or more people.

NH *A 07/89 (-) New Hampshire established in January a new coverage group, Children with Severe Disabilities (CSD). Children must be under age 18, meet medical disability criteria, and AFDC income and resource requirements with parental deeming.
In addition, New Hampshire added home care for CSDs who can be served cost-effectively at home.

NH *A 05/89 (+) New Hampshire changed its medically needy spenddown period from 6 months to 1 month. While the application and its information remain valid for 6 months, eligibility is redetermined monthly.


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IV. ALTERNATIVE SERVICE DELIVERY/PROGRAM MANAGEMENT

1. ACUTE CARE

AL *A 01/89 (-) Alabama established HMO coverage in two additional counties.

ME *A 01/89 (+) Maine now permits HMO enrollment to Medicaid recipients receiving AFDC and residing within the service area of a participating HMO. All AFDC recipients in that person's family must be enrolled in the HMO.

MA *A 09/89 (-) Massachusetts entered into selective contracting agreements for medical transportation in certain areas of the state.

NJ *A 07/89 (-) New Jersey requires Medicaid patients enrolled in the Garden State Health plan to have all services except transportation, dental services and second opinion consultations prior authorized by the physician case manager.

OR *A 11/89 (+) Oregon increased the DRG unit value to $1883 for admissions.

OR *A 11/89 (+) Oregon reimburses rural hospitals with fewer than 50 beds and less than 30 miles from another acute care hospitals at 100% of costs.

OR *A 03/89 (+) Oregon set End Stage Renal Dialysis reimbursement at 80% of the Medicare maximum allowable charge.

OR *A 03/89 (+) Oregon reduced coverage of sealants under its dental program to children age 15 and under. Sealants are covered for permanent molars only.

WA *A 07/89 (+) Washington contracted for transportation brokers to assure non-ambulance transportation to and from covered services.

WA *A 03/89 (-) Washington implemented a managed health care plan, administered by the Columbia Health Service in one county, to provide comprehensive care on a voluntary enrollment basis to AFDC recipients. The plan includes inpatient and outpatient hospital services

and physician care. All services, except emergencies, must be authorized through the recipient's primary care physician.

2. LONG TERM CARE

GA *B 01/90 (+) Georgia proposed the following rate changes to the community care services waiver program:

Adult Day Rehabilitation-$40 full day; $24 half day
Homemaker Aide Services - $8 per 1/2 hour;
Alternative Living Services - family and group model personal care home rates - $18.38 per day;
Respite Services - $9 per hour;
Home Delivered Services - 14 percent increase, up to a maximum of 6.13 per visit; and,
Personal Care Aide - $8.27 per 1/2 hour ($700 maximum per month).

The proposed changes are expected to increase aggregate expenditures by $2,827,748.

GA *B 07/89 ( ) Georgia proposed increasing the hourly rate of supported employment in its Mental Retardation Waiver Program from $4.01/hour to $5.95/hour with a maximum of 80 hours per month. Payment will be capped at $477.00 per month.

GA *B 01/89 (+) Georgia proposed to begin implementation of the Community Care for the Mentally Retarded waiver program, which will offer community-based services to a limited number of individuals who would otherwise require ICF/MR institutionalization. The program will be phased in by county. Services and reimbursement rates would include:

Homemaker Aide	$ 7.50 per half hour
Home Health Aide	$ 27.54 per visit
Personal Care Services	$ 20.00 per visit
Day Habilitation	$ 40.37 per day
Supported Employment	$ 4.01 per hour
Minimal Support- Level I Respite	$ 3.38 per hour
Moderate Support- Level II Respite	$ 4.05 per hour
Major Support- Level III Respite	$ 5.40 per hour
Intensive Support- Level IV Respite	$ 6.76 per hour
Residential Training & Supervision	$125.15 per day

KY *A 06/89 (-) Kentucky extended its HCBW program to 6 remaining counties,allowing provider agencies to submit proposals for one or more counties.
ties.

3. OTHER APPROACHES

AL *A 12/89 (+) Alabama expanded its Maternity Waiver Program to three more counties. The program is designed to provide, through a single provider, a case managed, coordinated system of care to pregnant women.

AL *A 06/89 (+) Alabama lifted its moratorium on new hospital beds, which had been established on October 1, 1983.

AL *A 06/89 (+) Alabama lifted its moratorium on new nursing home beds, which had been established on April 1, 1983.

ID *A 01/89 (+) Idaho added specialized services for qualifying pregnant women. These services include risk management, reimbursed by a monthly flat fee; individual and family social services, up to 2 visits per covered period; up to 2 nutrition services visits by a registered dietician per covered period; and up to 2 nursing visits per period.

MD *A 07/89 (+) Maryland implemented a Healthy Start Program for pregnant women and high-risk infants and children under age six. Enriched services include care coordination for pregnant women, risk assessment, nutritional counselling, home visitation, and health education.

MA *A 01/90 (+) Massachusetts implemented an insurance buy-in program for people with AIDS/ARC who have a disability determination and with income and assets below 300% the poverty level.

MI *A 10/89 (-) Michigan implemented a 2-year pilot program to assist persons with AIDS to pay health insurance premiums. The program is aimed at assisting people with ARC or AIDS in continuing insurance coverage after they become too ill to work.

To qualify, an individual's income must be below 200 percent of poverty, and have cash assets of less than $10,000. Medical expenses and insurance premiums can be deducted from gross income when determining whether the 200% guideline is met. Additionally, loss or substantial risk for losing employment-related health insurance because of AIDS related disease must be documented.

NY *A 09/89 (+) New York implemented its Expanded Health Care Coverage Act of 1988, providing health insurance coverage to the uninsured. Five pilot programs will take place throughout the state, for a period of 20 months. The Department of Health (DOH) will subsidize insurance premiums for individuals/families with income under 200% of poverty. DOH will also assist employers with fewer than 20 employees in providing health coverage. DOH and the employer will each pay 50% of the premium for the employees.

OH *A 01/89 (+) Ohio initiated Healthy Start, a program for women and infants, by expanding eligibility for pregnant women and infants with incomes up to 100% of poverty. No resource test is used with this group.

WA *A 08/89 (+) Washington expanded eligibility for pregnant women and infants up to 185% of poverty. In addition, eligibility was extended to children up to age 8 in families with incomes up to 100% of poverty. Both actions were part of Washington's First Steps Program, which also includes case management for high-risk recipients, maternity support services, increased maternity provider fees, and new fees for risk assessment and high-risk pregnancies. The program includes state-only funds to allow access for non-Medicaid women.
Medicaid also participates in identification of maternity distressed areas and works with the identified counties to develop alternative delivery systems for their residents.

APPENDIX I:
FEDERAL MEDICAL ASSISTANCE PERCENTAGES
(FMAP)

	FY 1986	FY 1987	FY 1987**	FY 1988	FY 1989	FY 1990
AL	72.30	72.41	72.41	73.29	73.10	73.21
AK	50.00	50.00	50.00	50.00	50.00	50.00
AS	50.00	50.00	50.00	50.00	50.00	50.00
AZ	62.28	62.13	62.28**	62.12	62.04	60.99
AR	73.83	74.02	74.02	74.21	74.14	74.58
CA	50.00	50.00	50.00	50.00	50.00	50.00
CO	50.00	50.00	50.00	50.00	50.00	52.11
CT	50.00	50.00	50.00	50.00	50.00	50.00
DE	50.00	50.00	50.00	51.90	52.60	50.00
DC	50.00	50.00	50.00	50.00	50.00	50.00
FL	56.16	55.54	56.16**	55.39	55.18	54.70
GA	66.05	64.54	66.05**	63.84	62.78	62.09
GU	50.00	50.00	50.00	50.00*	50.00*	50.00*
HI	51.00	51.29	51.29	53.71	50.99	54.50
ID	69.36	71.08	71.08	70.47	72.71	73.32
IL	50.00	50.00	50.00	50.00	50.00	50.00
IN	62.82	62.92	62.92	63.71	63.71	63.76
IA	58.90	60.39	60.39	62.75	62.95	62.52
KS	50.00	51.39	51.39	55.20	54.93	56.07
KY	70.23	70.75	70.75	72.27	72.89	72.95
LA	63.81	65.77	65.77	68.26	71.07	73.12
ME	68.86	68.07	68.86**	67.08	66.68	65.20
MD	50.00	50.00	50.00	50.00	50.00	50.00
MA DPW	50.00	50.00	50.00	50.00	50.00	50.00
MA BLIND	50.00	50.00	50.00	50.00	50.00	50.00
MI	56.79	56.88	56.88	56.48	54.75	54.54
MN	53.41	52.98	53.41**	53.98	53.07	52.74
MS	78.42	78.50	78.50	79.65	79.80	80.18
MO	60.62	59.85	60.62**	59.27	59.96	59.18
MT	66.38	67.44	67.44	69.40	70.62	71.35
NE	57.11	58.06	58.06	59.73	60.37	61.12
NV	50.00	50.00	50.00	50.25	50.00	50.00
NH	54.92	53.28	54.92**	50.00	50.00	50.00
NJ	50.00	50.00	50.00	50.00	50.00	50.00
NM	68.94	69.68	69.68	71.52	71.54	72.25
NY	50.00	50.00	50.00	50.00	50.00	50.00
NC	68.18	68.40	69.18**	68.68	68.01	67.46
ND	55.12	56.41	56.41	64.87	66.53	67.52
NMI	50.00	50.00	50.00	50.00*	50.00*	50.00
OH	58.30	58.27	58.30**	59.10	58.98	59.57

FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP) (CONTINUED)

	FY 1986	FY 1987	FY 1987**	FY 1988	FY 1989	FY 1990
OK	57.60	59.86	59.86	63.33	66.06	68.29
OR	61.54	62.47	62.47	62.11	62.44	62.95
PA	56.72	57.28	57.28	57.35	57.42	56.86
PR	50.00	50.00	50.00	50.00*	50.00*	50.00*
RI	56.33	55.38	56.33**	54.85	55.88	55.15
SC	72.70	72.23	72.70**	73.49	73.08	73.07
SD	67.82	67.45	67.82**	70.43	71.02	70.90
TN	70.20	70.26	70.26	70.64	70.17	69.64
TX	53.56	55.16	55.16	56.91	59.04	61.23
UT	72.62	73.21	73.21	73.73	73.86	74.70
VT	67.06	67.37	67.37	66.23	63.92	62.77
VA	53.14	51.86	53.14**	51.34	51.20	50.00
VI	50.00	50.00	50.00	50.00*	50.00*	50.00*
WA	50.06	52.52	52.52	53.21	53.06	53.88
WV	71.53	72.59	72.59	74.84	76.14	76.71
WI	57.54	57.58	57.58	58.98	59.31	59.28
WY	50.00	54.20	54.20	57.96	62.61	65.95

* FOR PURPOSES OF SECTION 1118 OF THE SOCIAL SECURITY ACT, THE PERCENTAGE USED UNDER TITLES I, X, XIV, AND XVI AND PART A OF TITLE IV WILL BE 75 PER CENTUM

** THE HOLD HARMLESS PROVISION HAS BEEN ENACTED AS PART OF THE SIXTH OMNIBUS BUDGET RECONCILIATION ACT OF FY 1986, P.L. 99-509, SECTION 9421, GIVING THESE 13 STATES THE RIGHT TO USE THEIR FY 1986 FMAP RATES FOR FY 1987.

SOURCE: HEALTH CARE FINANCING ADMINISTRATION

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